STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297089	A. BUILDING _____ B. WING _____	06/09/2009

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PRESTIGE HOME HEALTH CARE INC.	3690 S. EASTERN AVE., SUITE 226 LAS VEGAS, NV 89109

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G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare re-certification survey conducted at your agency from 6/1/09 through 6/9/09, in accordance with 42 CFR Part 484 - Home Health Services. The active census on the first day of the survey was 74. Fifteen clinical records were reviewed, including four closed records. Five home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The agency failed to maintain condition level compliance with the following Conditions of Participation: 42 CFR 484.14 - Organization, services, and administration 42 CFR 484.18 - Acceptance of patients, plan of care, medical supervision 42 CFR 484.20 - Reporting of OASIS information 42 CFR 484.30 - Skilled nursing 42 CFR 484.36 - Home health aide services 42 CFR 484.52 - Evaluation of the agency's program The following regulatory deficiencies were identified:	G 000		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the	G 116		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 116	Continued From page 1 State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the agency failed to advise patients of the toll-free state home health hotline number. Findings include: On 6/2/09 in the afternoon, a home visit was conducted with Employee #4 at the home of Patient #4. The surveyor asked Patient #4 if the agency nurse informed her about the state home health hotline number. Patient #4 did not recall, but Employee #4 indicated she was not familiar with the hotline number, where to locate the number in the agency in home folder, and did not know that patients should have been informed about the number.	G 116		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.	G 121		

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G 121	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview, record review, and document review, the agency failed to ensure care was provided in accordance with accepted standards of practice for 6 of 15 patients (#11, #8, #3, #4, #7, #14). Findings include: Review of the Nurse Practice Act, revised September 2007, revealed that Licensed Practical Nurses (LPN) contribute to the assessment of health status by: collecting, reporting and recording objective and subjective data. An interview with the Director of Nursing (DON) (Employee #1) and the Quality Assurance nurse (Employee #2) on 6/4/09, revealed the agency used the Mosby Home Health Guidelines. The agency policy identified as Standards of Practice indicated the agency "will provide services that are in compliance with acceptable professional standards for the Home care industry as well as all state and federal laws and identified agency performance improvement standards." Patient #11 Patient #11 was seen by the licensed practical nurse (LPN- Employee #6) at 7:00 PM on Friday, 4/3/09, for an additional visit. The caregiver had called the agency's office and reported the patient was complaining of pain in his ankle and requested an additional visit. The LPN's additional visit clinical note revealed the patient was instructed to tell the physician about the pain on his next physician visit or, if the pain continued, to go to the emergency room. There was no evidence the LPN notified the primary physician	G 121		

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G 121	Continued From page 3 or the case manager as defined by the Nurse Practice Act. Patient #8 Patient #8 was admitted on 11/8/08, with the primary diagnosis of decubitus ulcers of the lower back. The admission record revealed there were three pressure ulcers. At the time of admission, the ulcers were identified as stage two ulcers and were measured. An Ulcer/wound form was filled out but this form only identified two of the three ulcers. There was no other data on the form to demonstrate any further assessments. Documentation revealed Patient #8 was assigned one primary registered nurse (RN-Employee #5) during his care with the agency. His length of stay was from 11/8/08 through 4/21/09 at the time of his death. The clinical notes revealed that the wounds were not measured and assessed every week. New wounds developed on Patient #8's lower back, and an entry on recertification also indicated that Patient #8 fell, and required stitches to his head and hand, but these wounds were not assessed every visit or measured every week, including on the initial occurrence. Patient #8 was hospitalized on 1/20/09-2/2/09 and returned home with a wound vacuum assisted closure (VAC) system, to improve the wound healing on his lower back. Patient #8 also had a peripherally inserted central catheter (PICC line) for the administration of intravenous antibiotics. There was no evidence these sites were assessed either every visit or when the wound VAC dressing was changed. There were no weekly measurements.	G 121		

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G 121	Continued From page 4 Patient #8's primary nurse (Employee #5) was interviewed on 6/2/09. She acknowledged she had completed a wound care program to become a wound care nurse. She acknowledged that wounds should be measured every week, and observed/assessed every visit in home health care. A memo given to all nurses on 3/19/09, had directed staff on the required documentation for each visit and weekly assessments for wound care and PICC line sites. Review of the training and inservice programs at the agency revealed Employee #5 was trained in the agency's polices for wound and PICC line care. Cross refer G 143 Cross refer G 157 Patient #3 Patient #3 was admitted on 3/12/09 with diagnoses including osteoporosis, hypertension, paralysis and dysthymic disorder. The patient lived in an assisted living facility and was incontinent of urine. On 6/2/09 in the afternoon, a home visit was conducted at Patient #3's home with the registered nurse (RN) Employee #4. While waiting for the nurse to arrive, Patient #3 sat in his electric wheelchair with soiled clothing and needed assistance. When the nurse arrived, she placed her medical bag on the counter without placing a barrier	G 121		

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G 121	Continued From page 5 between the surface and the bag. At the end of the visit, Patient #3 was transferred to a chair and Employee #4 placed her medical bag on top of the seat of the electric wheelchair without using a barrier. Patient #4 Patient #4 was admitted on 10/23/08 with diagnoses including persistent insomnia, constipation, hypertension and arthropathy. On 6/1/09 in the afternoon, a home visit was conducted at the home of Patient #4 with Employee #4. Upon entering the home Employee #4 placed her bag on top of the patient's kitchen table without using any barrier between the surface and the bag. Patient #7 Patient #7 was admitted on 1/5/09 with diagnoses including non-insulin diabetes mellitus, congestive heart failure, hypertension and long-term use of blood thinners. On 6/2/09 in the morning during a home visit with Patient #7, the RN arrived pulling a wheeled nursing bag. After instructing Patient #7 about a new regimen of documenting foods eaten and blood sugar results, the RN reached into the nursing bag and removed a blood pressure cuff and a stethoscope. The RN did not clean the equipment prior to taking Patient #7's vital signs (blood pressure, pulse).	G 121		

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G 121	Continued From page 6 The RN looked at and touched Patient #7's sock-covered feet and then listened to the patient's lungs with the stethoscope. Prior to returning the blood pressure cuff and stethoscope to the bag, the RN did not perform hand hygeine nor did she clean the equipment During an interview on 6/4/09 in the morning, Patient #7's RN explained that she didn't clean the blood pressure cuff and stethoscope before putting them in the bag because she normally cleaned the equipment just prior to using it. The RN also explained that she always carried her bag and that, because it had wheels, it was ok to leave on the floor. According to the agency's Bag Technique policy (from the "Manual of Home Health Nursing Procedures" copyright 1995, Mosby-YearBook), "... 11. Clean all equipment with soap and water or home health agency-approved disinfectant when providing patient care ... Never place ... soiled equipment or dressings in the nursing bag ..." The same reference source indicated home health care workers were to wash their hands each time prior to reaching into the bag for anything, as well as to keep the number of times entered into the bag at a minimum. Patient #14 Patient #14 was admitted on 7/13/08 (and readmitted after each of two subsequent admissions to the hospital) with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension.	G 121		

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G 121	Continued From page 7 On the 7/13/08 and 7/22/08 the registered nurse (RN) documented Patient #14 had "2+" (pitting) edema in both lower extremities. On 7/25/08 and 7/28/08, the RN documented Patient #14 had "1+" (pitting) edema in both lower extremities. On 8/8/08, the RN documented Patient #14 had "tr" (trace) edema in both lower extremities. Out of 31 total visits, the RN failed to document findings of an assessment of the lower extremities. The visit notes lacked measurements of the lower extremities. According to the agency's reference Manual of Home Health Nursing Procedures, nurses caring for patients with congestive heart failure (CHF) should "...7. Weigh the patient at each visit... b. Instruct the patient to weigh himself or herself each morning before breakfast and after first voiding and to record the weight. Instruct the patient to notify the physician of a 2-pound weight gain in 1 day...9. Measure the edematous area each visit..."	G 121		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: The agency: failed to maintain ongoing liaison among the governing body, the group of professional personnel and the staff (G133); failed to ensure the administrator employed qualified personnel and ensured adequate staff education and evaluations (G134); failed to	G 122		

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G 122	Continued From page 8 coordinate patient services with all personnel to maintain liaison to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care (G143); failed to establish effective interchange, reporting and coordination of care (G144); failed to ensure a written summary for each patient was sent to the attending physician at least every 60 days (G145). The cumulative effect of these systemic practices resulted in the failure of the agency to deliver statutorily mandated care to its patients.	G 122		
G 133	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on interview and document review, the agency failed to have the administrator maintain a liaison between the governing body and the quality assurance committee. Findings include: On 6/4/09 in the afternoon, Employee #2 could not produce quarterly evaluation results for the second, third and fourth quarters of 2008. Employee #2 could not produce the review results of the first quarter for 2009. Employee #2 indicated the reviews from the above dates were not complete so she could not identify any issues from the reviews. There was no documented	G 133		

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G 133	Continued From page 9 evidence the reports were presented to the governing body and the governing body had not asked for the missing reports. On 6/4/09 in the afternoon, the Director of Nursing (DON) indicated on-site home staff evaluations, to determine if care was performed properly by the field staff, were not being done. The Administrator was not aware if on site staff evaluations were being performed. On 6/4/09 in the afternoon, the Administrator indicated the agency stopped sending questionnaires over two years ago to patients homes to evaluate the care the field staff were providing. There was no documented evidence the governing body approved to stop sending the questionnaires to the patients. Employee #2 indicated the agency had no process to determine if goals had been met. When issues that were identified and in-services were implemented to correct the issues there was no follow up evaluation to assess if the in-services were effective. There was no documented evidence measured results were given to the governing body by the quality assurance committee.	G 133		
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on record review, interview, and document	G 134		

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G 134	Continued From page 10	G 134		

review, the administrator failed to ensure 1) annual evaluations were conducted for 6 of 15 full time employees and 3 contracted staff; 2) staff received adequate education; and 3) the Quality Management Director was qualified for the position.

Findings include:

Employee #1

Employee #1 was a registered nurse (RN) hired on 7/2/07, to perform skilled nursing visits. In August of 2008, she became the acting Director of Nurses (DON).

Employee #1's personnel file lacked documented evidence of an annual performance evaluation for the past year.

Employee #2

Employee #2 was an RN hired on 7/23/07, to perform quality assurance on documentation of all care provided.

Employee #2's personnel file lacked documented evidence of an annual performance evaluation for the past year.

Employee #3

Employee #3 was an RN hired under contract on 7/9/02, as a wound care specialist.

Employee #3's personnel file lacked documented evidence of an annual performance evaluation for the past three years.

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G 134	Continued From page 11 Employee #4 Employee #4 was an RN hired on 5/21/07, to perform skilled nursing visits. Employee #4's personnel file lacked documented evidence of an annual performance evaluation for the past two years. Employee #5 Employee #5 was an RN hired on 4/18/07, to perform skilled nursing visits. Employee #5's personnel file lacked documented evidence of an annual performance evaluation for the past two years. Employee #6 Employee #6 was a licensed practical nurse (LPN) hired on 2/16/00, to perform skilled nursing visits. Employee #6's personnel file lacked documented evidence of an annual performance evaluation for the past three years. Employee #8 Employee #8 was a certified nursing assistant (CNA) hired on 5/10/07, to perform/assist patients with personal care. Employee #8's personnel file lacked documented evidence of 1) an annual performance evaluation for the past two years; and 2) continuing education for the past two years.	G 134		

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G 134	Continued From page 12 Employee #9 Employee #9 was a physical therapist (PT) hired under contract on 6/22/01. Employee #9's personnel file lacked documented evidence of 1) an annual performance evaluation for the past three years; and 2) continuing education for the past three years. Employee #11 Employee #11 was a speech language pathologist (SLP) hired under contract on 10/13/99, to perform speech therapy in the patients' homes. Employee #11's personnel file lacked documented evidence of an annual performance evaluation for the past three years. Employee #2's position at the agency since September 2008 was the Quality Management Director. Employee #2's State of Nevada Nursing license expired on 7/15/08. The agency's job description form (undated) listed qualifications for the Quality Management Director: - "...1. Has current valid Nevada registered Nurse License..." - "...2. A registered nurse with a baccalaureate or higher degree in nursing or other health related fields with experience in a home heath agency, primary care clinic or health facility..."	G 134		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES	G 143		

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G 143	Continued From page 13 All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all personnel communicated with each other in order to effectively coordinate and support the plan of care for 4 of 15 patients (#1, #5, #6, #11). Findings include: Patient #1 Patient #1 was admitted on 12/31/08, with diagnoses including chronic airway obstruction, shortness of breath and coronary artery disease. The patient was seen by nursing, physical therapy (PT) and a social worker. On 1/8/09, the physical therapist evaluated Patient #1 and initiated twice a week visits. There was no documented evidence PT communicated with the nurse managing the case regarding the status of PT services, frequency of visits, etc. On 1/12/09, the social worker evaluated Patient #1. There was no documentation indicating the social worker communicated with the nurse managing the case regarding the outcome of the evaluation and what services would be provided, how many visits would be made, etc. On 1/16/09, the licensed practical nurse (LPN) documented two medications had been changed; on 2/3/09, two more medication changes.	G 143		

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G 143	Continued From page 14 On 2/23/09, the LPN documented Patient #1 was experiencing an increase in thick mucous and having difficulty managing (expectorating) it. On 2/27/09, the LPN documented Patient #1 was put on two new medications and his blood thinner dosing was changed. On 5/9/09, the LPN documented Patient #1's blood thinner dosing was changed. There was no documentation indicating the LPN had notified the registered nurse case manager regarding the changes in Patient #1's medications. The record lacked documented evidence the three disciplines communicated with each other regarding the patient's care, progress, plans and status. Patient #5 Patient #5 was admitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer, urinary incontinence and generalized muscle weakness. Patient #5 was seen by nursing and a certified nursing assistant (CNA). A nursing visit note dated 4/18/09 revealed Patient #5 was experiencing signs and symptoms of a urinary tract infection (UTI). The nursing note lacked documentation indicating the nurse notified the certified nursing assistant CNA regarding the: 1) UTI; 2) new antibiotics; 3) need for meticulous Foley care; 4) need to drink plenty	G 143		

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G 143	Continued From page 15	G 143		

of water; and 5) signs/symptoms to watch for which would indicate an allergic reaction to the antibiotics.

Patient #6

Patient #6 was a 90 year-old female admitted on 5/16/09 with diagnoses including a stage two pressure ulcer on her coccyx and dementia. She resided in an assisted living facility, on a secure wing, requiring access codes for entrance and exits. Patient #6 required frequent prompting for all of her activities of daily living and had limited comprehension for health teachings. Patient #6's plan of care indicated skilled nursing visits were scheduled twice a week.

An on-site visit with registered nurse (RN), Employee #4, was conducted on 6/2/09 at 9:30 AM. The RN informed this surveyor that even though the stage two pressure sore had resolved, she was planning to continue the home health interventions because she was concerned that Patient #6 was losing weight. The primary nurse reported that the assisted living facility only weighed the residents once a month, and Patient #6 required a wheel-chair scale, because she could not stand independently. This nurse reported that during her last visit, she asked the facility to weigh Patient #6. She was told that the scales were locked up and no one had access to them. Employee #14 was told that Patient #6 would be weighed in two weeks.

An interview between Employee #4 and a staff member of the assisted living facility revealed that Employee #4 only asked how Resident #6 was eating. Employee #4 did not ask to see the chart,

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G 143	Continued From page 16 or confirm if a weight had been obtained. Review of the assisted living facility chart for Patient #6 revealed the patient had been weighed the week of 5/25/09, and had lost one pound from the previous month. Patient #11 Patient #11 was a 93 year-old male admitted on 1/23/09 with diagnoses including atrial fibrillation, hypertension, hypothyroidism and abnormal weight loss. Review of his clinical record revealed that he required two hospitalizations (4/10/09 - 4/15/09 and 4/23/09-5/16/09). On 5/22/09, Patient #11 was seen by the social worker to be evaluated for alternative living arrangements. The social worker documented that an unnamed individual was the durable power of attorney for health care who would arrange to find an assisted living facility that accepted Patient #11's insurance. There was no phone contact number listed for this individual. There was no documentation indicating the social worker informed the registered nurse case manager of this plan. On 6/5/09 during a telephone interview, the social worker confirmed she did not communicate with the registered nurse case manager. The social worker reported that she told someone in the office, she thought it may have been clerical staff. Cross refer G 121 Cross refer G144	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES	G 144		

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G 144	Continued From page 17	G 144		

The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.

This STANDARD is not met as evidenced by:
Based on interview, record review and document review, the agency failed to ensure case conferences establishing effective reporting, interchange and coordination of patient care occurred for 11 of 15 patients (#1, #5, #7, #10, #14, #12, #15, #2, #8, #9, #11).

Findings include:

Patient #1

Patient #1 was admitted on 12/31/08, with diagnoses including chronic airway obstruction, shortness of breath and coronary artery disease.

Patient #1 was seen by skilled nursing and physical therapy (PT).

Patient #1's clinical record contained a "Case Conference Form" dated 2/27/09. The nurse case manager filled out the form. The form lacked evidence PT was involved in the case conference.

Patient #1's clinical record contained a form with "Case Conference" at the top. The nurse and the physical therapist each made an entry. The nurse signed the form at the bottom in the area provided. The form was not signed by the PT. The form was undated.

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G 144	Continued From page 18 Patient #5 Patient #5 was admitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness. Patient #5 was seen by skilled nursing and a certified nursing assistant (CNA). Patient #5's clinical record contained a form with "Case Conference" at the top. The nurse made an entry. The nurse signed the form at the bottom in the area provided. The form lacked documentation by the CNA. The form was undated. Patient #5's clinical record contained a "Case Conference Form", dated 3/12/09. The nurse case manager filled out the form. The form lacked documentation and evidence the CNA was involved in the case conference. Patient #7 Patient #7 was admitted on 1/5/09 with diagnoses including diabetes mellitus, congestive heart failure, hypertension and long-term use of blood thinners. Patient #7 was seen by skilled nursing only. Patient #7's clinical record contained a form with "Case Conference" at the top. The nurse made an entry and an illegible signature was on the signature line. The form was undated. Patient #7's clinical record contained two "Case Conference Forms" which were dated 3/2/09 and 5/4/09. The nurse case manager entered information on the front of both forms. The back	G 144		

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G 144	Continued From page 19 of the 5/4/09 form lacked documentation and the nurse's signature. There was no indication the nurse conferenced with others regarding the patient's situation and plans for care. Patient #10 Patient #10 was admitted on 4/23/03 with diagnoses including pressure sore, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. Patient #10 was seen by skilled nursing only. Patient #10's clinical record contained an incomplete and undated "Case Conference" form with entries and signatures of the the licensed practical nurse and the registered nurse. Patient #10's clinical record contained an incomplete "Case Conference Form" dated 3/21/09, signed by the registered nurse. There was no documentation indicating the nurse conferenced with others regarding the patient's situation and plans for care. Patient #14 Patient #14 was admitted on 7/13/08 with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension. Patient #14 was seen by skilled nursing only. Patient #14's clinical record contained a "Case Conference Form" dated 3/12/09. The nurse case manager filled out the form and signed it. There was no documentation indicating the nurse conferenced with others regarding the patient's situation and plans for care.	G 144		

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G 144	Continued From page 20 Patient #14's clinical record contained a form with "Case Conference" at the top. The nurse case manager made an entry and signed the form at the bottom in the area provided. The form was undated. On 6/2/09 in the morning, the Director of Nursing indicated case conferences were held for each patient 30 days after admission and at the time of recertification (60 - 62 days after admission). On 6/2/09 in the morning, the Administrator agreed that a case conference of one person did not constitute a case conference. According to the agency's policy and procedures book by Briggs Corporation, entitled Home Health Agency Medicare Manual, "...1. Multi-disciplinary case conferences are conducted every month; 30 days after the start of care ... and prior to each patient recertification..." Patient #12 Patient #12 was admitted on 3/9/09 with diagnoses including hypertension and decubitus ulcer. Patient #12 was also taking Coumadin. On 3/11/09 the nursing visit record revealed Patient #12 was seen by the wound care nurse to evaluate open wounds to the lower extremities. The patient complained to the wound care nurse regarding rectal bleeding with bowel movements. The physician was notified by the wound care nurse. Subsequent visits were completed by Employee	G 144		

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G 144	Continued From page 21 #14 and there were no further assessments completed regarding Patient #12's rectal bleeding. There was no documented evidence Employee #14 was informed by the wound care nurse regarding Patient #12's complaint with rectal bleeding. Patient #15 Patient #15 was admitted on 2/5/09 with diagnoses including paralysis, esophageal reflux, constipation, and non-organic sleep disorder. Under the "changes in condition" section of the Home Health Aide form dated 2/24/09, the certified nursing assistant (CNA) documented Patient #15 had edema to the left hand. There was no documented evidence the nurse was informed of the change. On Patient #15's Home Health Aide form dated 4/21/09, under the "changes in condition" section, the documentation revealed the CNA had noted blood in the patient's rectal area. There was no documented evidence the nurse was informed of the change. Patient #2 Patient #2 was on service from 8/29/08 until 12/2/08. His clinical record revealed two undated case conference forms. One form contained an entry from the registered nurse and the physical therapist, the second form was signed by a second registered nurse, a licensed practical nurse and the physical therapist. Patient #8	G 144		

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G 144	Continued From page 22 Patient #8 was admitted 11/8/08 and was recertified for two additional recertification periods. The RN (Employee #5) was the primary nurse. A case conference form was filled out on 1/2/09 and 3/6/09 by Employee #5 but there was no evidence any other disciplines were involved, therapy and the certified nursing assistant (CNA) were present. There were no personal care needs identified although the CNA was going twice a week. The clinical record also contained forms that were identified as case conferences, but were undated. Patient #9 Patient #9 was admitted to the agency on 10/17/07. Review of the clinical record for the past two recertification periods revealed there was only one undated case conference form and this was only completed by the CNA. There were no entries by the RN. Patient #11 Patient #11 was admitted to the agency on 1/23/09. Review of the clinical record for the past two recertification periods revealed a case conference form filled out on 5/19/09, by the RN (Employee #14). There was no case conference sign in sheet to indicate this information was shared with the CNA. An interview with a registered nurse (RN), Employee #4 was conducted on 6/2/09. This nurse described the process of the case conferences. She replied that the forms for the case conference sheets were completed independently by the various disciplines. She	G 144		

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G 144	Continued From page 23 confirmed there was no interdisciplinary conference. The various disciplines would fill out their own sections. She did not respond to the question of who then coordinated the care or needs as identified on the case conference form. Cross refer G 143	G 144		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to ensure a written summary report was prepared and made available to the attending physician every 60 days for 14 of 15 patients (#1, #5, #7, #10, #14, #12, #4, #13, #3, #15, #2, #8, #9, #11). Findings include: Patient #1 Patient #1 was admitted on 12/31/08, with diagnoses including chronic airway obstruction, shortness of breath and coronary artery disease. The 60-day summaries for the periods ending 2/28/09 and 4/29/09 lacked information regarding 1) Patient #1's condition at the beginning of each 60-day period; 2) treatments and services provided during the most recent certification period, and; 3) the patient's response to the treatments and services provided during each period.	G 145		

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G 145	Continued From page 24 Patient #5 Patient #5 was admitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness. The 60-day summaries for the periods ending 3/11/09 and 5/10/09 lacked information regarding: 1) Patient #5's condition at the beginning of each 60-day period; 2) treatments and services provided during the (just completed) certification period, and; 3) the patient's response to the treatments and services provided during each certification period. Patient #7 Patient #7 was admitted on 1/5/09 with diagnoses including diabetes mellitus, congestive heart failure, hypertension and long-term use of blood thinners. The 60-day summaries for the periods ending 3/5/09 and 5/4/09 lacked information regarding 1) Patient #7's condition at the beginning of the 60-day period; 2) treatments and services provided during the (just completed) certification period, and; 3) the patient's response to the treatments and services provided during each certification period. Patient #10 Patient #10 was admitted on 4/23/03 with diagnoses including pressure sore, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. The 60-day summaries for the periods ending	G 145		

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G 145	Continued From page 25 3/21/09 and 5/20/09 lacked information regarding 1) Patient #10's condition at the beginning of the 60-day period; 2) treatments and services provided during the (just completed) certification period, and; 3) the patient's response to the treatments and services provided during each certification period. Patient #14 Patient #14 was admitted on 7/13/08 with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension. The 60-day summaries for the periods ending 3/9/09 and 5/7/09 lacked information regarding 1) Patient #14's condition at the beginning of the 60-day period; 2) treatments and services provided during the (just completed) certification period, and; 3) the patient's response to the treatments and services provided during each certification period. On 6/2/09 in the morning, the Administrator acknowledged that the form they were currently using did not solicit the information required for a complete and accurate 60-day summary. According to the agency's policy and procedures book by Briggs Corporation, entitled Home Health Agency Medicare Manual, "...The summary will include a written report of the client's current condition, the treatment/services provided, and the client's response to the current treatment and/or medications... The progress note/physician summary will be completed by the appropriate professional staff	G 145		

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G 145	Continued From page 26 member ... The summary note will include: a. Clinical summary for each discipline providing care or services identifying health status and progress noted during time frame; b. Response to service and rehabilitative services provided; c. Current needs and plan for continued care ..." Patient #12 Patient #12 was admitted on 3/9/09 with diagnoses including hypertension and decubitus ulcer. The 60-day summary for the period ending 5/5/09 in the clinical record lacked information about 1) Patient #12's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period and; 3) the patient's response to the treatments and services provided during each certification period. Patient #4 Patient #4 was admitted on 10/23/08 with diagnoses including persistent insomnia, constipation, hypertension, and arthropathy. The 60-day summaries for the periods ending 12/17/08, 2/17/09, 4/20/09 lacked information about 1) Patient #4's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period and; 3) the patient's response to the treatments and services provided during each certification period. Patient #13	G 145		

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G 145	Continued From page 27 Patient #13 was admitted on 3/10/09 with diagnoses including diabetes, decubitus ulcer, hypertension, and chronic kidney disease. The 60-day summary for the period ending 5/6/09 lacked information about 1) Patient #13's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period and; 3) the patient's response to the treatments and services provided during each certification period. Patient #3 Patient #3 was admitted on 3/12/09 with diagnoses including osteoporosis, hypertension, paralysis, and dysthymic disorder. The 60-day summary for the period ending 5/6/09 lacked information about 1) Patient #3's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period and; 3) the patient's response to the treatments and services provided during each certification period. Patient #15 Patient #15 was admitted on 2/5/09 with diagnoses including paralysis, esophageal reflux, constipation, and non organic sleep disorder. The 60-day summary for the period ending 4/5/09 lacked information about 1) Patient #15's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period and; 3) the patient's response to the treatments and services provided	G 145		

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G 145	Continued From page 28 during each certification period. Patient #2 Patient #2 was admitted on 8/29/08, with diagnoses including decubitus ulcer of the buttocks, open wound of the toe, diabetes, hypertension and debility. Patient #2 was recertified 60 days later with chronic airway obstructive disease, decubitus ulcer of the buttock, hypertension, diabetes mellitus and debility. Review of the clinical summaries for both certification periods were essentially unchanged: "71 year old male patient homebound due to considerable and taxing effort related to Severe shortness of breath, unable to safely leave home unassisted, bedbound. Lives with wife." There was no documentation of the status of the decubitus ulcer, the intervention of physical therapy and its effectiveness or the resolution of the open wound to the toe. Patient #8 Patient #8 was admitted on 11/08/08 with pressure sores to his lower back. He remained with the agency for approximately six months until his death on 4/21/09. The clinical record revealed Patient #8 required hospitalization and a need for surgical revision of his wounds. He returned home requiring intravenous antibiotics and hi-tech wound care treatments using a wound vacuum assisted closure (VAC) system. He also had developed a Methicillin resistant staph aureus (MRSA) infection.	G 145		

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G 145	Continued From page 29 Review of the 60 day summaries for the initial clinical summary (11/8/08) and the recertification clinical summaries for 1/7/09, and 3/8/09 were essentially unchanged: "69 year old male patient homebound due to considerable and taxing effort related to: requires assistance to ambulate, severe shortness of breath, shortness of breath on exertion, dependant upon adaptive devices, need assistance for all activities, unable to safely leave home unassisted." There was no documentation of the progression of decline or healing of the decubitus ulcer, what changes in wound care were attempted, the requirement of hospitalization, the development of the MRSA infection or the need for intravenous antibiotics. There was no documentation of the patient's refusal to use the wound VAC system on 3/7/09. Patient #9 Patient #9 was admitted on 10/17/07. Review of the clinical record revealed that Patient #9 required home health care related to the need for anticoagulation therapy and unstable lab results. Patient #9 was to have monthly lab work to monitor the effectiveness of the anticoagulation therapy. Review of the last two 60-day summaries, 2/8/09 and 4/9/09, were essentially unchanged: "73 year old female patient homebound due to considerable and taxing effort related to severe shortness of breath, requires assistance to ambulate, oxygen therapy, residual weakness." There was no documentation of the monthly lab	G 145		

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G 145	Continued From page 30 results or what anticoagulation therapy changes were required. Further review of the clinical record revealed that for the past six months, Patient #9's lab work had remained stable, and labs were not done in Jan, March or May. The record also revealed there had been no change in the anticoagulation therapy dose for at least the past six months. Patient #11 Patient #11 was admitted on 1/23/09. Review of the clinical record revealed that his admission clinical summary as well as the two recertification summaries, 3/24/09 and 5/23/09 were essentially the same: "93 year old male patient homebound due to considerable and taxing effort related to residual weakness." There was no documentation that Patient #11 had two prolonged hospitalizations in April and May of 2009, or that he had a change in condition, currently requiring anticoagulation therapy for blood clots. Patient #11's last hospitalization was from 4/23/09-5/17/09. He was recertified on 5/19/09. These hospitalizations would have been included in the 60 day summary for the recertification period of 3/24/09-5/22/09. Cross refer G 303	G 145		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: The agency: failed to accept patients for treatment on the basis of a reasonable	G 156		

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G 156	Continued From page 31 expectation that the patient's medical, nursing and social needs could be met adequately by the agency in the place of residence (G157); failed to render care that followed a written plan of care as established and periodically reviewed by a doctor of medicine and failed to promptly alert the physician of any changes that suggested a need to alter the plan of care (G158); failed to develop a plan of care in consultation with the agency staff that covered the mental status of patients, the functional limitations; prognosis and activities permitted and included instructions for timely discharge (G159); failed to review the plan of care with the attending physician and HHA personnel as often as the patient's condition required but at least once every 60 days (G163); and failed to administer drugs and treatments only as ordered by the physician (G165). The cumulative effect of these systemic practices resulted in the failure of the agency to deliver services statutorily mandated by the Federal regulations for acceptance of patients, the plan of care and medical supervision.	G 156		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on interview and record review,, the agency failed to ensure that 1 of 15 patients who needed every six hours administration of intravenous antibiotics had his needs adequately	G 157		

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met by the agency (#8).

Findings include:

Patient #8

Patient #8 was admitted to the agency on 11/8/08, with the primary diagnosis of decubitus ulcers of the lower back. On admission there were three stage two ulcers identified. The admission data indicated that Patient #8 was 69 years old, lived by himself and was legally blind. He had a paid caregiver. Patient #8 also had restricted movement with his right arm.

An interview with the registered nurse (RN), Employee #5 at 10 AM on 6/3/09, confirmed she was the primary nurse for Patient #8 for the length of his home health stay, from 11/8/08 until 4/21/09, when the patient expired at home. Employee #5 confirmed that Patient #8 lived by himself and was legally blind. Employee #5 reported that the "paid caregiver" identified on admission was a Medicaid homemaker, who performed personal care three times a day.

Review of the clinical record revealed that there was a decline in the wound status as well as occurrence of more wounds on the lower back/buttocks area. Patient #8 was admitted to the hospital on 1/30/09 for surgical revision of the wounds.

The agency resumed care on 2/3/09. The hospital discharge orders received by the agency revealed that Patient #8 had osteomyelitis. He was to receive two antibiotics, Vancomycin 1.5 grams intravenous every 12 hours and Zosyn 3.375 grams intravenous every six hours. These

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intravenous medications were to be administered through a peripherally inserted central catheter (PICC).

The re-admission visit was conducted by Employee #5 at 6:00 PM on 2/3/09. The reassessment data revealed Patient #8 still lived by himself, was legally blind and still had the paid caregiver.

In the re-admission assessment, the RN documented that Patient #8 could not manage his own medications. A friend administered the oral medications, but there was no documentation who this friend was. The RN also indicated that the caregiver required someone to set up equipment such as intravenous/infusion therapy. There was no documentation that any caregiver, friend, neighbor or anyone except Patient #8 was present. There was no documentation that any friend or caregiver was going to administer the intravenous antibiotics: Zosyn (every six hours) or Vancomycin (every 12 hours).

The RN documented that during this visit she administered the intravenous Vancomycin, but did not document that she administered the Zosyn. She also documented that she used isolation precautions because Patient #8 had methicillin resistant staph aureus infection (MRSA). There was no documentation that anyone else was present for the RN to instruct regarding the need to use aseptic/sterile techniques while administering the intravenous antibiotics or accessing the PICC line (to prevent infection).

The next documented visit was at 12:00 PM on 2/4/09. The RN documented that she administered a dose of Zosyn. There was no

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evidence that Employee #5 evaluated whether the Vancomycin had been given as ordered every 12 hours, which would have been due at 6 or 7 AM, 12 hours from the last evening's dose. There was no evidence that Employee #5 evaluated whether any Zosyn had been administered prior to the dose she administered at noon. Again, there was no documentation that anyone else was present.

The next documented visit was at 5:30 PM on 2/5/09. This visit note indicated Employee #5 administered both the Zosyn and Vancomycin. The RN documented that she instructed the patient on how to flush the PICC, but he was unable to return the demonstration because of poor dexterity of his fingers.

Review of Employee #5's remaining clinical notes, starting at Patient # 8's return home following his hospitalization and antibiotic therapy revealed that Employee #5 did not perform intravenous infusion of Zosyn every six hours or Vancomycin every 12 hours. Nor was there any documentation that there was anyone in the home taught to administer the antibiotics, that the proper techniques for administration and prevention of infection were taught or that whomever was taught could return demonstration of the procedures and techniques. The frequency the first week was only daily for four days. There were no visits made on the weekend. Patient #8 was seen daily for five days with no visits made on the weekend. The skilled nursing frequency was then changed to three times a week.

An interview with the RN on 6/3/09 revealed Patient #8 allegedly had a roommate. This roommate was never identified in the clinical record, nor was it identified when the roommate

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G 157	Continued From page 35 arrived. Employee #5 confirmed she did not observe this roommate performing any of the procedures to ensure his/her competency. An interview with the Director of Nursing (DON) and the Administrator at 1:30 PM on 6/4/09 revealed that when the agency received the orders for the intravenous antibiotics and their frequency, the primary RN was informed and asked if she could manage the required frequency; every six hours/ every 12 hours and she informed them that she could. The DON stated "we would have referred him to another agency if we couldn't provide the necessary care." It was also confirmed that the agency did not reassess the RN's compliance with the required frequencies or intravenous antibiotic therapy ordered. Cross refer G121 Cross refer G 158 Cross refer G 165 Cross refer G 169	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure care followed the written plan of care for 9 of 15 patients (#1, #5, #10, #14, #4, #2, #11, #9, #8). Findings include:	G 158		

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G 158	Continued From page 36 Patient #1 Patient #1 was admitted on 12/31/08 and was re-admitted on 1/7/09, with diagnoses including chronic airway obstruction, shortness of breath and coronary artery disease. 1. The resumption plan of care dated 1/8/09, indicated skilled nursing (SN) was to see Patient #1 two times a week for one week; three times a week for two weeks; two times a week for two weeks; and one time a week for three weeks for the certification period ending 2/28/09. The actual frequency of SN visits for Patient #1, beginning 1/8/09 was one time a week for one week; four times a week for one week; three times a week for one week; two times a week for one week; three times a week for one week; two times a week for one week; one time a week for one week; and two times a week for one week. Patient #1's plan of care/physician's orders for the certification period of 3/1/09 - 4/29/09 read, "SN 1W9" (one time a week for nine weeks). The actual SN frequency was two times a week for eight weeks and one time a week for one week. An order dated 3/2/09 read, "Correction to 485 2W6, 1W3" (two times a week for six weeks and one time a week for three weeks). The order did not include an effective date for these visits. 2. The plan of care/physician's orders for the certification period of 12/31/08 through 2/28/09, indicated physical therapy (PT) was to see Patient #1 two times a week for seven weeks. The actual PT frequency was two times a week	G 158		

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for three weeks; no visits were made for one week; then two times a week for four weeks.

Patient #1's clinical record lacked documentation indicating the physician was aware the patient was not seen during the fourth week by PT. There was no missed visit report indicating why the patient was not seen by PT during the fourth week.

Patient #1's clinical record contained a physician's order, dated 2/27/09 reading, "PT 2 x 1 week (two times a week for one week) to increase strength, transfers, gait training." The order did not include an effective date for these visits.

Patient #1's plan of care/physician's orders for the certification period of 3/1/09 - 4/29/09 read, "PT 2W7" (two times a week for seven weeks). The actual PT frequency was two times a week for seven weeks and one time a week for one week.

Patient #5

Patient #5 was admitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness.

Patient #5's clinical record contained a physician's order for skilled nursing (SN) one time a week for nine weeks. The clinical record contained a missed visit report (MVR) indicating the patient was not seen on 1/29/09.

The clinical record did not have a phyician's order to decrease the visits (to none) for the week of 1/25/09.

On 6/2/09 in the morning, the Director of Nursing

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acknowledged the frequencies did not follow the plan of care as ordered by the physician.

Patient #10

Patient #10 was admitted on 4/23/03 with diagnoses including pressure sores, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus.

For the certification period of 1/21/09 through 3/21/09, the plan of care revealed Patient #10 was to be seen by a skilled nurse (SN) two times a week for nine weeks and (up to) two times as needed for Foley catheter problems.

During the first week of the 1/21/09 - 3/21/09 period, Patient #10 was seen by a SN one time. For the following six weeks, the patient was seen three times a week. On the last week of the certification period, the patient was seen four times.

A physician's prescription order in Patient #10's clinical record, dated 1/8/09, read "Accuzyme # as directed."

A Verbal Order Confirmation (VOC) dated 1/9/09, read "SN to provide wd (wound) care with cleansing of both decubitus c (with) normal saline coccyx, et (and) Lt (left) posterior upper hip, then pat dry et apply accuzyme et DSD (dry sterile dressing) 2xW (two times a week)."

A Urinary Bladder Disease (Foley Care) Axial Visit Note (UBDFCAVN), dated 1/23/09, revealed the SN "...cleansed both wounds with normal saline and applied Panafil to rid them of necrotic tissue."

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G 158	Continued From page 39 A UBDFCAVN dated 1/27/09 revealed the SN "... cleansed both wounds with normal saline, applied Panafil..." On 1/29/09, the certified wound, ostomy and continence nurse (CWOCN) assessed Patient #10's pressure sores and recommended 1) the left hip wound be dressed with "alginate or hydrofiber with silver and covered with a dry dressing daily" and 2) the coccyx be dressed with "alginate or hydrofiber with silver and covered with dressing as needed for drainage ..." A UBDFCAVN dated 2/2/09 revealed the SN "... cleansed both wounds with normal saline, applied Panafil to rid them of necrotic tissue." A VOC dated 2/4/09, read "SN to increase wd (wound) care to 3xW (three times a week) and SN will instruct CG (caregiver) on how to change dressing if soiled." The order did not specify the effective date of the increase in SN visit frequencies for Patient #10. A VOC dated 2/5/09, indicated Patient #10's wound dressing product was changed. The VOC lacked any indication of the frequency and duration of the new wound care or the need to re-evaluate the effect the new wound care was having. According to the Outcome and Assessment Information Set (OASIS) transfer form, Patient #10 was transferred to an acute care facility on 5/18/09, secondary to wound infection/deteriorating wound status. Patient #14	G 158		

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G 158	Continued From page 40 Patient #14 was admitted on 7/13/08 (and reassessed after two subsequent admissions to the hospital) with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension. The initial plan of care for Patient #14 (certification period of 7/13/08 through 9/10/08) indicated the skilled nurse (SN) was to see the patient two times a week for three weeks and then once a week for six weeks. The SN saw Patient #14 one time the first week; two times a week for three weeks; and then one time a week for four weeks. Patient #4 Patient #4 was admitted on 10/23/08 with diagnoses including persistent insomnia, constipation, hypertension, and arthropathy. On 6/1/09 in the afternoon, a home visit was conducted at the home of Patient #4 with the registered nurse (RN) Employee #4. Patient #4 complained of right elbow pain. Employee #4 assessed slight swelling to the area and referred the pain and swelling to a fall sustained several months ago. On 6/2/09 in the afternoon, a telephone interview with Patient #4's son was conducted. The son indicated Patient #4 sustained a fall and injured her left eye at the end of March. The son indicated Patient #4 had a black eye for several weeks. The son had issues regarding nursing	G 158		

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coverage. The son indicated that missed visits with the nurse had occurred 2 to 3 times in a six month period. The son indicated he was not contacted by the nurse prior to the missed visits.

Missed skilled visits occurred the weeks of 1/27/09, 3/29/09, and 5/24/09. The 10/23/08, 12/17/08, 2/17/09, and 4/20/09 plan of care ordered skilled nurse visits once a week.

On 6/2/09 in the afternoon, Employee #4 indicated during the week of 3/29/09 a skilled visit was not made and Patient #4 sustained a fall injuring her left eye. A missed visit was documented for the week. The next skilled visit was completed on 4/10/09. There was no documented evidence the fall or the injury was reported to the physician. Subsequent visits lacked any assessments to the right eye injury. Employee #4 confirmed she did not document the fall or document the assessed injuries. Employee #4 indicated she did not inform the physician regarding the fall and injury.

Patient #2

Patient #2 was admitted to the agency on 8/29/08. His primary diagnoses included diabetes, decubitus ulcer and debility. The clinical record revealed Patient #2's skilled nursing frequency remained at two times a week for both certification periods. There was no record of skilled nurse visits the week of 8/31/08, and only one skilled nurse visit for the weeks of 9/21/08, 9/28/08, 11/16/08, and 11/23/08. There was no evidence in the clinical record that these were missed visits or that the physician had been informed. The patient expired at home on

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G 158	Continued From page 42 12/23/08. Patient #2's initial referral also included a physician's order for physical therapy and occupational therapy. There was an entry that on 9/8/08, Patient #2 refused occupational therapy, but there was no evidence that the physician was informed. Physical therapy was started on 9/8/08 with a frequency of twice a week. There were no physical therapy visits during the week of 9/14/08 and the week of 9/28/08. There was no evidence in the clinical record that these were missed visits or that the physician had been informed. An entry on the skilled nursing visit dated 11/21/08, by the licensed practical nurse (LPN) documented Patient #2 was taking nitroglycerin for chest pain. There was no evidence that nitroglycerine was part of Patient #2's medication profile, nor was there evidence that the physician had been informed that Patient #2 was having chest pain. Patient #2's physician ordered a urine culture on 10/27/08. This was obtained 10/27/08 and the final results revealed an infection of Pseudomonas aeruginosa, in which antibiotics would be effective. There was no evidence the lab result was sent to the physician or that the primary nurse contacted the physician for antibiotic therapy. Patient #11 Patient #11 was admitted to the agency on 1/23/09, with the diagnoses of atrial fibrillation, hypertension, chronic pain, hypothyroidism and abnormal weight loss.	G 158		

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Review of the clinical record revealed that the recertification period of 5/23/-7/21/09 contained the home health aide frequency of 0 w 1 (zero week one), the twice a week for eight weeks. "Zero" was not considered an allowable frequency. There was no evidence that the agency contacted the physician to clarify this frequency.

The clinical record revealed that an additional skilled nursing visit was made after hours on 4/3/09. The LPN made the visit because Patient #11 was complaining of foot pain. The LPN did not contact the case manager or the physician to inform them about Patient #11's complaints. There was no evidence that the physician was contacted to obtain an order for the additional visit.

The clinical record revealed Patient #11 was seen by the social worker on 5/22/09. There was no evidence in the clinical record that the physician was contacted to obtain an order for the social worker visit.

Patient #9

Patient #9 was admitted to the agency on 10/17/07. A recertification assessment completed on 2/6/09, revealed the primary nurse (Employee #5) documented the lab results which monitored the effectiveness of the anticoagulation therapy fluctuated and were low. Review of the last two certification periods revealed that lab work was ordered to be done every month by the home health agency to monitor the effectiveness of the anticoagulant therapy.

Review of Patient #9's lab work and

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anticoagulation therapy prescription revealed that from November 2008 through May 2009, there were no lab tests obtained in January, March and May. There was no evidence the physician had been informed the monthly lab tests were not done as ordered. There was no evidence the obtained lab results were sent to the physician.

Patient #8

Patient #8 was admitted to the agency 11/8/08, for treatment of decubitus ulcers of the lower back and buttocks. Patient #8 was initially ordered to be seen by the certified nursing assistant (CNA) twice a week. This frequency continued through 4/21/09. Only one CNA visit was made the weeks of 11/30/08 and 1/1/09. There was no evidence of missed visits or that the physician was informed.

An entry by the registered nurse (RN), Employee #5 on 11/12/08, revealed she had attempted to insert a Foley catheter without success, because of an obstruction. Review of the clinical record revealed there were no physician orders to insert a Foley catheter. There was no documentation that Employee #5 had requested the Foley catheter, that Patient #8 was having difficulty voiding or that the physician was informed that the catheter could not be inserted. Employee #5 did not document she instructed Patient #8 to monitor his urine for possible signs/symptoms trauma, such as blood in the urine, inability to void, or pain when he urinated.

Patient #8 was seen by the wound care nurse on 11/18/08. The current wound orders were to clean with normal saline, pat dry and apply a dry dressing. The wound care nurse documented

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that the wound on the sacrum was 4.0 centimeters (cm) by 8 cm (length and width) and 1.0 cm deep with moderate, yellow drainage, with a slight odor. This wound had been 2 cm by 2 cm with no depth, scant drainage with no odor approximately 10 days prior. The wound care nurse recommended: to apply calcium alginate to the (now) stage three area, and cover all the wounds with a hydrocolloid dressing, securing with tape around the border.

The wound nurse documented she contacted the primary nurse case manager (Employee #5). Subsequent clinical visits for Patient #8 revealed the recommended wound care was performed, but there was no documentation or evidence the physician was informed of the recommendations and prescribed change in wound care. There was also no evidence the physician was informed of the change in condition of the pressure sores, from stage two to stage 3.

The wound care nurse made another visit on 1/15/09 and documented that Patient #8's wound was now a stage four, with a length of 7 cm, a width of 5 cm and a depth of 1 cm. Drainage was large and yellow. There was also undermining at both 1-5 o'clock and 7-10 o'clock. The nurse recommended the use of a wound vac. On 1/16/09, Employee #5 instructed Patient #8 on the wound vac that would start in a few days, but there was no evidence that the physician was informed of the recommendations of the wound care nurse or of the deteriorating change in the wounds.

The clinical record revealed that Patient #8 was admitted to the hospital on 1/30/09, resumed home health care on 2/3/09. He had the wound

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G 158	Continued From page 46 vacuum system and required intravenous antibiotics: Zosyn every six hours and Vancomycin every 12 hours. Patient #8 had a percutaneous inserted central catheter (PICC) for this therapy. Review of the clinical record revealed that there was no evidence that the home health agency administered the intravenous antibiotics as ordered. There was no evidence that the home health agency ensured that there was someone capable to administer the antibiotics. There was no evidence the physician was informed. The clinical record also revealed on 3/16/09, that the patient refused any further wound vacuum therapy. There was no evidence the physician was informed of Patient #8's refusal for further wound vac therapy. Cross refer G 157 Cross refer G 159 Cross refer G 165 Cross refer G 196	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on interview and record review, the agency	G 159		

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G 159	Continued From page 47 failed to ensure 1) plans of care for patients were developed to cover all pertinent diagnoses to meet patients' needs, including medications and plans for discharge or referral, by failing to request history and physicals for 7 of 15 patients (#5, #6, #11, #9, #2, #8, #7); and 2) the appropriate utilization of a certified nursing assistant's services for 1 of 15 patients (#8). Findings include: 1. Review of four active clinical records and three closed records revealed that although the individual patients signed releases for the agency to receive medical history and physicals from the physician, there were no history and physicals located in the records. The five active records were for: - Patient #5, originally admitted on 7/26/06 and re-admitted on 3/11/09. - Patient #6, admitted on 5/16/09. - Patient #11, admitted on 1/23/09. - Patient #7, admitted on 1/5/09. - Patient #9, an active patient since admission on 10/17/07. The two closed records were for: - Patient #2, a patient of the agency from 8/29/08 to 12/3/08. - Patient #8, a patient of the agency from 11/8/08 to 4/21/09. An interview with the Director of Nursing (DON) and the Administrator on 6/2/09 at 2:00 PM confirmed that no request for a history and physical for these patients had been sent to the primary physician.	G 159		

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G 159	Continued From page 48 2. Patient #8 Patient #8 was admitted on 11/8/08. His admission assessment indicated that he was 69 years old, lived alone, was legally blind and had limited range of motion to his upper extremities. He also had a paid caregiver. This assessment was completed by the registered nurse (RN), Employee #5. Employee #5 initiated a certified nursing assistant (CNA) to assist with personal care twice a week. The CNA continued at this frequency for the duration of Patient #8's home health stay, 11/8/08-4/21/09. An interview with Employee #5 at 10:00 AM on 6/3/09, revealed Patient #8's paid caregiver was a Medicaid assigned homemaker who assisted Patient #8 three times a day. Her duties included personal hygiene care. Employee #5 acknowledged this was a duplication in service, but reported that Patient #8 often refused the personal care from the paid caregiver. Employee #8 acknowledged she did not contact Medicaid or the physican to report this. Cross refer G 157 Cross refer G 158 Cross refer G 236	G 159		
G 163	484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the	G 163		

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same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.

This STANDARD is not met as evidenced by:
Based on interview, record review and document review, the agency failed to ensure the total plan of care was reviewed by the attending physician at least every 60 days for 5 of 15 patients(#1, #5, #7, #10, #14).

Findings include:

Patient #1

Patient #1 was admitted on 12/31/08, with diagnoses including chronic airway obstruction, shortness of breath and coronary artery disease.

The 60-day summaries for the periods ending 2/28/09 and 4/29/09 lacked information regarding 1) Patient #1's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period, and; 3) the patient's response to the treatments and services provided during each certification period.

Patient #5

Patient #5 was admitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness.

The 60-day summaries for the periods ending 3/11/09 and 5/10/09 lacked information regarding

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G 163	Continued From page 50 1) Patient #5's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period, and; 3) the patient's response to the treatments and services provided during each certification period. Patient #7 Patient #7 was admitted on 1/5/09 with diagnoses including diabetes mellitus, congestive heart failure, hypertension and long-term use of blood thinners. The 60-day summaries for the periods ending 3/5/09 and 5/4/09 lacked information regarding 1) Patient #7's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period, and; 3) the patient's response to the treatments and services provided during each certification period. Patient #10 Patient #10 was admitted on 4/23/03 with diagnoses including pressure sore, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. The 60-day summaries for the periods ending 3/21/09 and 5/20/09 lacked information regarding 1) Patient #10's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period, and; 3) the patient's response to the treatments and services provided during each certification period.	G 163		

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G 163	Continued From page 51 Patient #14 Patient #14 was admitted on 7/13/08 with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension. The 60-day summaries for the periods ending 3/9/09 and 5/7/09 lacked information regarding 1) Patient #14's condition at the beginning of the 60-day period; 2) treatments and services provided during the most recent certification period, and; 3) the patient's response to the treatments and services provided during each certification period. On 6/2/09 in the morning, the Administrator acknowledged that the form they were currently using did not solicit the information required for a complete and accurate 60-day summary. According to the agency's policy and procedures book by Briggs Corporation, entitled Home Health Agency Medicare Manual, "...The summary will include a written report of the client's current condition, the treatment/services provided, and the client's response to the current treatment and/or medications... The progress note/physician summary will be completed by the appropriate professional staff member ... The summary note will include: a. Clinical summary for each discipline providing care or services identifying health status and progress noted during time frame; b. Response to service and rehabilitative services provided; c. Current needs and plan for continued care ..."	G 163		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS	G 165		

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G 165	Continued From page 52 Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure drugs and treatments were administered by staff only as ordered by the physician for 8 of 15 patients (#1, #5, #10, #2, #6, #8, #9, #11). Findings include: Patient #1 Patient #1 was admitted on 12/31/08 (and readmitted on 1/7/09), with diagnoses including chronic airway obstruction, shortness of breath and coronary artery disease. 1. The resumption plan of care dated 1/8/09 indicated skilled nursing (SN) was to see Patient #1 two times a week for one week; three times a week for two weeks; two times a week for two weeks; and one time a week for three weeks for the certification period ending 2/28/09. The actual frequency of SN visits for Patient #1, beginning 1/8/09 was one time a week for one week; four times a week for one week; three times a week for one week; two times a week for one week; three times a week for one week; two times a week for one week; one time a week for one week; and two times a week for one week. 2. The plan of care/physician's orders for the certification period of 12/31/08 through 2/28/09, indicated physical therapy (PT) was to see Patient	G 165		

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G 165	Continued From page 53 #1 two times a week for seven weeks. The actual PT frequency was two times a week for three weeks; no visits were made for one week; then two times a week for four weeks. 3. On a SN Visit Note dated 1/16/09, the licensed practical nurse (LPN) wrote "Lasix 10 mg (milligram) change...Coreg D/c'd" (discontinued). The Medication Profile revealed Patient #1 had been taking Lasix 20 mg one tablet every day and Coreg 12.5 mg one tablet every morning. The clinical record lacked documented evidence the physician gave the order to change the medications. The Medication Profile was not updated to reflect the changes made. There was no documentation indicating the LPN spoke with the registered nurse (RN) who was managing the case with regard to the medication changes. An LPN's visit note dated 2/3/09, indicated Patient #1's medications were changed as follows: -- Coumadin dose was changed to 5 mg 1 tablet on Monday, Tuesday, Wednesday, Thursday and Saturday; 1.5 tablets on Friday; and -- Coreg 3.125 mg one tablet by mouth twice a day was restarted. According to the initial Medication Profile in the medical record, Patient #1 was taking Coumadin 5 mg 1 tablet by mouth on Sunday, Wednesday and Saturday and 1.5 tablet on Monday, Tuesday, Thursday and Friday. The changes noted by the nurse on the visit note were not noted on the Medication Profile.	G 165		

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G 165	Continued From page 54 The clinical record lacked a physician's order for Patient #1's medication changes as noted on the 2/3/09 SN visit note. An LPN's visit note dated 2/27/09, indicated Patient #1 was taking Azithromycin, Mucous Relief and Tessalon Perles. The medical record lacked documented evidence of a physician's order for the new medications. The new medications were not listed on the Medication Profile. The 2/27/09 visit note indicated Patient #1's Coumadin was changed to 7.5 mg on Monday, Wednesday and Friday; and 5 mg on Tuesday, Thursday and Saturday. There was no physician's order for these changes. The Medication Profile was not updated with the changes. 4. The clinical record for Patient #1 contained an evaluation by the medical social worker (MSW), dated 1/9/09. The clinical record lacked an order for the MSW to evaluate the patient. Patient #5 Patient #5 was admitted on 7/26/06 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness. Patient #5 was hospitalized on 3/4/09 and discharged home on 3/11/09. The Registered Nurse (RN) performed a resumption of care visit on 3/12/09. The clinical record lacked a physician's order for a resumption of care visit after Patient #5's discharge from the hospital on 3/11/09.	G 165		

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G 165	Continued From page 55 Patient #10 Patient #10 was admitted on 4/23/03 with diagnoses including pressure sore, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. 1. The plan of treatment for the certification period of 1/21/09 through 3/21/09 contained orders for the SN to see Patient #10 two times a week for nine weeks. The start of the certification period (1/21/09) was a Wednesday. The patient was seen on 1/23/09, a Friday. The patient was seen once a week for the first week in the certification period of 1/21/09 through 3/21/09. Patient #10 was seen four times during the last week of the certification period of 1/21/09 through 3/21/09 (three times by the LPN and once by the RN for the recertification assessment). 2. The plan of treatment for the certification period of 3/22/09 through 5/20/09 contained orders for the SN to see Patient #10 three times a week for nine weeks. The nurse was to perform wound care and to teach the caregiver how to perform wound care. The nursing visit notes lacked documentation the caregiver verbalized understanding of the process and/or was able to return demonstrate the procedure. During the weeks of 4/5/09 and 4/12/09, Patient #10 was seen twice each week by nursing for wound care. The clinical record lacked documented evidence of a missed visit note and documentation the physician was notified that the patient was not seen a third time each week. During the week of 4/19/09, Patient #10 was seen	G 165		

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four times for wound care each visit. There was no documentation on the visit note indicating the reason for the extra visit.

Patient #2

Patient #2 was admitted on 8/29/08, with diagnoses including a pressure ulcer on the buttocks, open wound to the toe, diabetes mellitus, hypertension and debility.

1. The first certification period was from 8/29/08-10/27/08. The physician ordered wound care to be done daily. The clinical record revealed the next skilled nursing visit after admission on 8/29/08, occurred 13 days later. There was no evidence any caregiver had been observed performing wound care as ordered.

2. Review of the clinical notes revealed that on 11/21/08, the licensed practical nurse (LPN) documented Patient #2 was taking Nitroglycerin for occasional chest pain, but there was no documentation of the dose or instructions for the Nitroglycerin. There was no evidence that the LPN informed the case manager or the physician. There was no evidence that the medication profile review was updated in the clinical record.

3. Patient #2's initial referral included a physician's order for physical therapy and occupational therapy. There was documentation dated 9/8/08 indicating Patient #2 refused occupational therapy, but there was no evidence that the physician was informed.

4. Patient #2's physician ordered a urine culture on 10/27/08. This was obtained the same day.

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G 165	Continued From page 57 The final results obtained by the agency on 11/3/08 revealed an infection of Pseudomonas aeruginosa. Included with the results were the names of the antibiotics which would be effective in eliminating the infection. There was no evidence this lab result was sent to the physician, no was there any evidence the physician was contacted by the RN case manager for antibiotic therapy orders for Patient #2. Patient #11 Patient #11 was admitted on 1/23/09 with diagnoses including atrial fibrillation, hypertension, chronic pain, hypothyroidism and abnormal weight loss. 1. The clinical record revealed that an additional skilled nursing visit was made after hours on 4/3/09. The LPN made the visit because Patient #11 was complaining of foot pain. The LPN did not contact the case manager or the physician to inform them about Patient #11's complaints. There was no evidence that the physician had been contacted to obtain an order for the additional visit. 2. The clinical record revealed that Patient #11 had been seen by the social worker on 5/22/09. There was no evidence in the clinical record that the physician had been contacted to obtain an order for the social worker visit. Patient #9 Patient #9 was admitted to the agency on 10/17/07.	G 165		

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G 165	Continued From page 58 A recertification assessment completed on 2/6/09 revealed the primary nurse (Employee #5) documented Patient #9's labs which monitored the effectiveness of the anticoagulation therapy fluctuated and were low. There was no evidence that the lab results that were obtained had been sent to the physician. Review of the last two certification periods revealed the lab tests were ordered to be done every month by the home health agency to monitor the effectiveness of the anticoagulant therapy. Patient #9's lab work and anticoagulation therapy prescription revealed that from November 2008 through May 2009, no labs were obtained in January, March and May. There was no evidence the physician had been informed the monthly labs were not done as ordered. Patient #8 Patient #8 was admitted on 11/8/08, for treatment of decubitus ulcers of the lower back and buttocks. Patient #8 was seen by the wound care nurse on 11/18/08. The wound orders at that time were to clean with normal saline, pat dry and apply a dry dressing. The wound care nurse documented that the wound on the sacrum was 4.0 centimeters (cm) by 8 cm (length and width) and 1.0 cm deep with moderate, yellow drainage, with a slight odor. The wound had been 2 cm by 2 cm with no depth, scant drainage with no odor approximately 10 days prior. The wound care nurse recommended: to apply calcium alginate to the now stage three area, and cover all the wounds with a hydrocolloid dressing, securing	G 165		

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G 165	Continued From page 59 with tape around the border. The wound nurse documented she contacted the primary nurse case manager (Employee #5). Subsequent clinical visits for Patient #8 revealed the recommended wound care was being performed, but there was no documentation or evidence the physician had been informed of the recommendations and the prescribed change in wound care. There was also no evidence the physician had been informed of the change of condition of the pressure sores, from stage two to stage 3. The wound care nurse made another visit on 1/15/09 and documented that Patient #8's wound was a stage four, with a length of 7 cm, a width of 5 cm and a depth of 1 cm. Drainage was yellow and a large amount. There was also undermining from 1to 5 o'clock and from 7 to 10 o'clock. She recommended the use of a wound VAC (vacuum assisted closure). On 1/16/09, Employee #5 instructed Patient #8 about the wound VAC that would start in a few days, but there was no evidence that the physician had been informed. The clinical record revealed that Patient #8 was admitted to the hospital on 1/30/09. He resumed home health care on 2/3/09 and had the wound VAC. He required intravenous antibiotics: Zosyn every six hours and Vancomycin every 12 hours. Patient #8 had a peripherally inserted central catheter (PICC) for this therapy. Review of the clinical record revealed that there was no evidence the agency administered the intravenous antibiotics as ordered. There was no evidence the agency ensured there was someone capable to administer the antibiotics. There was no evidence the physician was informed.	G 165		

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G 165	Continued From page 60 The clinical record also revealed that on 3/16/09, the patient refused any further wound VAC therapy. There was no evidence the physician was informed of Patient #8's refusal for further wound VAC therapy. Patient #6 Patient #6 was admitted to the agency 5/16/09 with diagnoses including a stage two pressure ulcer on her coccyx and dementia. She was seen twice a week by the registered nurse (Employee #4) for wound care. Patient #6 resided at an assisted living facility in the secured unit. An interview with Employee #14 on 6/2/09, revealed the pressure ulcer had resolved by the visit made the week of 5/24/09, but Employee #4 was concerned about Patient #6's weight loss, which began prior to admission to home health. Employee #4 planned to continue seeing Patient#6 to monitor this weight loss. Employee #4 confirmed she had not contacted the physician during the past seven days to inform him of her observations and concerns. Cross refer G 158	G 165		
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: The agency: failed to furnish skilled nursing services by or under the supervision of a registered nurse (G169); failed to furnish skilled nursing services in accordance with the plan of care (G170); failed to ensure the skilled nurse	G 168		

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G 168	Continued From page 61 regularly re-evaluated the patient's nursing needs (G172); failed to ensure the registered nurse prepared necessary revisions of the plan of care (G173); failed to furnish those services requiring substantial and specialized skill (G174); failed to ensure the skilled nurse prepared clinical and progress notes, coordinated services, informed the physician and other personnel of changes in the patient's condition and needs (G176); failed to ensure the skilled nurse counseled the patient and family in meeting nursing and related needs (G177); failed to ensure the skilled nurse participated in in-service programs, and supervised and taught other nursing personnel (G178). The cumulative effect of these systemic problems resulted in the agency's inability to ensure the provision of federally mandated skilled nursing services.	G 168		
G 169	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services by or under the supervision of a registered nurse. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure skilled nursing services were furnished by or under supervision of a registered nurse for 4 of 15 patients (#2, #11, #9, #8). Findings include: Patient #2 Patient #2 was admitted to the agency on 8/29/08. His primary diagnoses included diabetes, decubitus ulcer and debility.	G 169		

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G 169	Continued From page 62 Patient #2 was being seen by a licensed practical nurse (LPN) starting on week seven of his first certification period. Patient #2 was recertified by a registered nurse on 10/25/08. The LPN continued to be the primary skilled nurse seeing Patient #2 until his death on 12/3/08. There was no evidence in the clinical record that the agency provided registered nursing supervision to the LPN's care the month of November. Patient #11 Patient #11 was admitted to the agency on 1/23/09, with the diagnoses of atrial fibrillation, hypertension, chronic pain, hypothyroidism and abnormal weight loss. The clinical record revealed that an additional skilled nursing visit was made after hours on 4/3/09. The LPN made the visit because Patient #11 was complaining of foot pain. There was no evidence that the LPN contacted the case manager or the physician to inform them about Patient #11's complaints. The clinical record revealed that Patient #11 had been seen by the social worker on 5/22/09. An interview with the social worker on 6/5/09, revealed she did not communicate with the primary registered nurse nor did the primary registered nurse contact the social worker regarding this visit. Patients #8 and #9 Patient #8 and Patient #9 were both assigned to be seen by the primary registered nurse (Employee #5). Both of these patients were being seen by a certified nursing assistant (CNA).	G 169		

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G 169	Continued From page 63 Review of Patient #8's last two recertifications revealed that Patient #8 had a CNA twice a week for four months without any documentation of CNA supervision. Review of the clinical record for Patient #9 revealed that he had a CNA twice a week from 11/8/08-4/20/09, without any documentation of CNA supervision. An interview with the primary nurse (Employee #5) on 6/3/09, revealed she never conducted any supervisory evaluations of the CNA's compliance with the plan of care because Employee #5 was not aware that it was her responsibility. Cross refer G 143	G 169		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on interview, record review, and document review, the agency failed to ensure that skilled nursing services were provided in accordance with the plan of care, specifically requiring every six and every 12 hour administration of intravenous antibiotics, peripherally inserted central catheter (PICC) care and wound vacuum care management for 1 of 15 patients (#8). Findings include: Facility policies for wound care directed that assessment of the status/condition of the wound include the character, location and size. Size was to be measured in centimeters (cm), with the	G 170		

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length being the horizontal (head to toe) and width being the vertical (right to left) and depth of the wounds. Wounds were also to be assessed for any signs and symptoms of wound infection such as redness, drainage, odor, pain and tenderness. Weekly wound sheet reports to describe the progress and development of the wound status were to be used.

An inservice provided by the wound care nurse on 4/7/08 was provided to the skilled nurses as well as copies of the inservice being delivered to the in office mailboxes of all skilled nurses. Employee #5 was employed at that time.

On 3/19/09, a memo was delivered to all skilled nursing staff, directing the agency's expectation of documentation for wound care and PICC lines. This memo indicated pictures of the wounds were to be taken on admission and every two weeks, with the patient's name, location, measurement (of the wounds), and date. Wounds were to be numbered to ensure consistent assessments. PICC lines were to be assessed every visit. This would include the insertion site, and leakage, redness or pain, the type of device, as well as the condition of the site and dressing. Wound care and PICC line care were to follow the physician's orders.

Patient #8

Patient #8 was admitted to the agency on 11/8/08, with the primary diagnosis of decubitus ulcers of the lower back. There were three stage two ulcers identified on admission. The admission data indicated that Patient #8 was 69 years old, lived by himself, and was legally blind. He did have a paid caregiver. Patient #8 also had

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restricted movement with his right arm.

An interview with the registered nurse (RN), Employee #5, at 10 AM on 6/3/09, confirmed that she was the primary nurse for Patient #8 for the length of his home health stay, from 11/8/08 until 4/21/09. She confirmed that he had expired at home on this date. Employee #5 confirmed that Patient #8 did live by himself and was legally blind. Employee #5 reported that the "paid caregiver" was a Medicaid homemaker, who came in to perform personal care three times a day.

1. The admission assessment dated 11/8/08, identified the three pressure ulcers, but none were identified with numbers (#1,2,3) to identify each for further reference. There were no photographs included in the record. The first wound at the lower back was a stage two pressure ulcer measuring 2 cm by 2 cm. with scant amount of sero-sanguinous drainage. The second wound at the lower right flank was stage two, measuring 1.2 cm by 1 cm with no drainage. The third wound at the coccyx was a stage two measuring 2.3 cm by 1.9 cm, with no drainage. Wound care was ordered three times a week.

On 11/18/08, Patient #8 was seen by the wound care nurse. The wound care nurse documented that the sacral wound was 4.0 cm by 8.0 cm by 1.0 cm with moderate amount of yellow drainage with a slight odor. She also identified bilateral lower buttock wounds, but had only one measurement 1.0 cm by 1.5 cm by 0.2 cm.

It could not be determined by documentation whether these wounds correlated with the three wounds initially observed, but there was evidence

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G 170	Continued From page 66 that there had been deterioration of the wounds. On 11/26/08, Employee #5 documented the wound on Patient #8's coccyx was cultured, wound care was provided to this and the wound on the right buttocks. Employee #5 also documented there were two small wounds near the rectum. None of the four wounds were described nor were the two new wounds measured. Employee #5 documented she covered the two wounds with DuoDerm"cut to 1 cm by 1 cm." The clinical record revealed Employee #5 continued to provide wound care three times a week for the next five weeks, but there were no further measurements or descriptions or status of the wounds, or any other skin assessment for a period of approximately 30 days until 1/2/09. A comprehensive assessment was completed by Employee #5 on 1/2/09. The wound assessment described two wounds. The first one was identified as a stage four wound at the sacrum, with heavy bloody drainage and odor, but there were no measurements. The second wound was located on the left heel, and had eschar over it. This wound was also not measured. There were no photos obtained. At this point, Patient #8 required wound care five times a week. A skilled visit conducted by the wound care nurse was completed on 1/15/09. Her documentation revealed the sacral wound was 7.0 cm by 5.0 cm by 1.0 cm. This wound also had undermining at 1-5 o'clock and 7-10 o'clock to 1.0 cm deep. Patient #8 was admitted to the hospital on 1/30/09, without any further documentation of his	G 170		

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wound status. His post hospital comprehensive assessment was completed on 2/3/09, by Employee #5 and identified one wound at the sacrum. The wound was a stage four pressure ulcer measuring 7.0 cm by 5.0 cm by 1.0 cm with moderate amount of sero-sanguinous drainage and no odor. There was no documentation that there was any undermining. Employee #5 documented Patient #8 had a PICC line located in his left upper arm. There was no documentation what this PICC site's appearance was or the size or type of line, such as a double lumen.

On 2/11/09, the sacral wound was measured at 6.7 cm, by 5.0 cm by 0.7 cm. On 2/16/09, the wound measured 6.0 cm by 6.3 com by 0.5 cm with a pink wound bed, and 20% red granulation tissue noted. There was moderate exudate.

On 3/6/09, eighteen days later, the next measurement of the sacral wound was during a comprehensive recertification assessment. The sacral wound was measured as 6.2 cm by 8.0 cm but there was no depth, although the wound was still classified as a stage four wound. The measurements revealed the wound had increased in width almost 75 %, but Employee #5 documented the wound had decreased minimally, and the depth was reduced to 0.2 cm. There was no documentation to demonstrate the PICC site had been assessed since Patient #8's return from the hospital more than one month ago.

Review of the remaining clinical notes from 3/6/09-4/21/09, confirmed Employee #5 had no documentation of any further wound measurement. The only PICC line assessment was documented on 4/4/09. The agency received a call from an unidentified caregiver that Patient

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G 170	Continued From page 68 #8 had expired at home on 4/21/09 at 6:17 AM. Review of the clinical notes revealed the primary nurse, Employee #5 did not follow the agency's protocols for wound care assessment and management, as well as those for PICC line care. 2. Patient #8 was admitted to the hospital on 1/30/09 and the agency resumed care on 2/3/09. The hospital orders received by the agency revealed that Patient #8 had osteomyelitis. He was to receive two antibiotics, Vancomycin 1.5 grams intravenous every 12 hours and Zosyn 3.375 grams intravenous every six hours. These intravenous medications were to be administered through a percutaneously inserted central catheter (PICC). The readmission visit was conducted by Employee #5 at 6:00 PM on 2/3/09. The reassessment data documented that Patient #8 still lived by himself, that he was legally blind, he still had a paid care giver. In the re-admission assessment, the RN documented that Patient #8 could not manage his own medications. A friend administered the oral medications, but this friend was not identified. There was no documentation that the caregiver (friend) was willing/able to assist with administration of any injectable or intravenous medications. The RN also indicated that the caregiver required someone to set up equipment such as intravenous/infusion therapy. There was no documentation that any caregiver, friend, neighbor or anyone except Patient #8 was present. Employee #5 documented that during this visit	G 170		

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she administered the intravenous Vancomycin, but did not document that she administered the Zosyn. She also documented that she used isolation precautions because Patient #8 had a methicillin resistant staph infection. There was no documentation that the RN instructed anyone on the need for aseptic or sterile techniques to access the intravenous antibiotics or accessing the PICC line to prevent infection.

A skilled nurse visit was completed the next day at 12:00 PM on 2/4/09. Employee #5 documented that she administered a dose of Zosyn. There was no evidence that Employee #5 evaluated whether the Vancomycin had been given as ordered every 12 hours, which would have been due at 6 or 7 AM, 12 hours from the last evening's dose. There was no evidence that Employee #5 evaluated whether any Zosyn had been administered prior to the dose she administered at noon.

The next documented visit was at 5:30 PM on 2/5/09. This visit indicated that Employee #5 administered both the Zosyn and Vancomycin. The RN documented that she instructed the patient on how to flush the PICC line, but he was unable to return the demonstration because of poor dexterity of his fingers. There was no documentation that Employee #5 assessed the compliance of the intravenous antibiotics being given at times that she was not there, who was giving them or if there were any problems.

Review of Employee #5's clinical notes, starting at Patient #8's return home following his hospitalization (2/3/09 through 4/21/09) revealed that Employee #5 did not perform intravenous infusion of Zosyn every six hours or Vancomycin

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G 170	Continued From page 70 every 12 hours. There was no documentation anyone in the home was taught to administer the antibiotics, the proper techniques for administration and prevention of infection were taught or whoever was taught could demonstrate the techniques. The frequency the first week was only daily for four days. There were no visits made on the weekend, then Patient #8 was seen daily for five days with no visits made on the weekend. His frequency was subsequently changed to three times a week. An interview with Employee #5 on 6/3/09, revealed Patient #8 allegedly had a roommate. This roommate was never identified in the clinical record, nor was it identified when the roommate arrived. She reported she did instruct this unidentified roommate, but confirmed she never had this individual perform return demonstrations to ensure competency. An interview with the Director of Patient Services (DoPS) and the Administrator at 1:30 PM on 6/4/09 revealed that when the agency received the orders for the intravenous antibiotics and their frequency, the primary RN was informed and asked if she could manage the required frequency (every six hours / every 12 hours) and she informed them that she could. The DoPS stated "we would have referred him to another agency if we couldn't provide the necessary care." It was also confirmed that the agency did not reassess the RN's compliance with the required frequencies or intravenous antibiotic therapy ordered. The DoPS also acknowledged that Patient #8's chart was not critiqued to evaluate whether the plan of care was followed. Cross refer G 121	G 170		

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G 170	Continued From page 71 Cross refer G 165 Cross refer G 158	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure the registered nurse regularly re-evaluated the nursing needs for 4 of 15 patients (#1, 8, 10, #12). Findings include: Patient #1 Patient #1 was admitted on 12/31/08, with diagnoses including chronic airway obstruction, shortness of breath and coronary artery disease. After Patient #1 was readmitted on 1/1/09, the licensed practical nurse (LPN) saw the patient 16 times over the course of seven weeks. On 2/23/09, the LPN documented the patient was experiencing an increase of mucous and was having difficulty coughing it up. The clinical record lacked documented evidence the registered nurse (RN) re-evaluated the patient's nursing needs at that time. On 4/22/09, the LPN documented Patient #1 was not taking medications as ordered and pre-poured by the LPN. The clinical record lacked documented evidence the RN re-evaluated the patient's nursing needs.	G 172		

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G 172	Continued From page 72 Patient #10 Patient #10 was admitted on 4/23/03 with diagnoses including pressure sores, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. After an RN wound care specialist consultant saw Patient #10 on 1/29/09, the LPN saw the patient eight consecutive times over two and a half weeks. On 2/19/09, the RN case manager did a supervisory visit. According to the documentation, the RN case manager did not perform wound care and did not re-evaluate the patient's wounds and nursing needs. Patient #12 Patient #12 was admitted on 3/9/09 with diagnoses including hypertension and decubitis ulcer. Patient #12 was also taking Coumadin. On 3/11/09 the nursing visit record revealed Patient #12 was seen by the wound care nurse to evaluate open wounds to the lower extremities. The patient complained to the wound care nurse regarding rectal bleeding with bowel movements. The physician was notified by the wound care nurse. Subsequent visits were completed by Employee #14 and there were no further assessments completed regarding Patient #12's rectal bleeding. There was no documented evidence Employee #14 was informed by the wound care nurse regarding Patient #12's complaint of rectal	G 172		

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G 172	Continued From page 73 bleeding. Patient #8 Patient #8 was admitted to the agency on 11/8/08, with the primary diagnosis of decubitus ulcers of the lower back. On admission it was identified that there were three stage two ulcers. The admission data indicated that Patient 8 was 69 years old, and lived by himself and was legally blind. He did have a paid caregiver. Patient #8 also had restricted movement with his right arm. Review of the clinical record revealed a deterioration of the wounds, requiring hospitalization. Upon Patient #8's return home, he had a peripherally inserted central catheter (PICC) placed, and subsequent intravenous antibiotic therapy every six hours (Zosyn) and every 12 hours (Vancomycin). The PICC line would need to be flushed with saline and Heparin after each dose of antibiotic. There was no evidence the primary nurse, Employee #5 re-evaluated Patient #8's increased need of someone competent to administer the intravenous antibiotics. An interview with Employee #5 on 6/3/09, revealed the paid caregiver was a Medicaid homemaker came three times a day. This homemaker was not allowed to administer intravenous antibiotics. Employee #5 acknowledged that Patient #8 had a roommate, but Employee #5 could not identify when the roommate started to live with Patient #5. She also confirmed she never assessed the capabilities of the roommate to administer	G 172		

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G 172	Continued From page 74 intravenous medications and maintain infection control procedures. Cross refer G 170 Cross refer G 173	G 172		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure the plan of care was revised to accommodate for intravenous antibiotics to be given every six hours for 1 of 15 patients (#8). Findings include: Patient #8 Patient #8 was admitted to the agency on 11/8/08, with the primary diagnosis of decubitus ulcers of the lower back. On admission it was identified that there were three stage two ulcers. The admission data indicated that Patient 8 was 69 years old, and lived by himself and was legally blind. He did have a paid caregiver. Patient #8 also had restricted movement with his right arm. Review of the clinical record revealed a deterioration of the wounds, requiring hospitalization. Upon Patient #8's return home, he had a peripherally inserted central catheter (PICC) placed, and subsequent intravenous antibiotic therapy every six hours (Zosyn) and every 12 hours (Vancomycin). The PICC line would need to be flushed with saline and Heparin	G 173		

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G 173	Continued From page 75 after each dose of antibiotic. Employee #5 was the primary nurse and made the post hospitalization visit on 2/3/09, and documented Patient #8 required every six hour antibiotic administration though the PICC line. Employee #5's next visit was at noon on 2/4/09. There was no evidence the primary nurse, Employee #5 re-evaluated Patient #8's increased need of someone competent to administer the intravenous antibiotics or that she instructed anyone in the home how to administer the antibiotics, flush the PICC line and observe infection control techniques on 2/3/09. An interview with Employee #5 on 6/3/09, revealed the paid caregiver was a Medicaid homemaker came three times a day. This homemaker was not allowed to administer intravenous antibiotics. Employee #5 acknowledged that Patient #8 had a roommate, but Employee #5 could not identify when the roommate started to live with Patient #5. She also confirmed she never assessed the capabilities of this roommate to administer intravenous medications and maintain infection control procedures. Cross refer G 170 Cross refer G 172	G 173		
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill.	G 174		

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G 174	Continued From page 76 This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to properly assess and measure wounds on a weekly basis for 5 of 15 patients (#4, #15, #12, #13, #10). Findings include: Patient #4 Patient #4 was admitted on 10/23/08 with diagnoses including persistent insomnia, constipation, hypertension, and arthropathy. Patient #4 ' s Wound/Ulcer/Incision Flow Sheet dated 4/28/09 documented a Stage I pressure ulcer to the coccyx area. The wound measured 3 centimeters (cm) by 1 cm. Patient #4 ' s Wound/Ulcer/Incision Flow Sheet dated 5/19/09 documented the same Stage I pressure ulcer to the coccyx area. There were no measurements documented on the form. There was no documented evidence measurements were made after the 4/23/09 to show the progression of the wound. On 6/3/09 in the afternoon, the Director of Nursing indicated Stage I ulcers needed to be measured every week. On 6/2/09 in the afternoon, Employee #4 indicated during the week of 3/29/09 a skilled visit was not made and Patient #4 sustained a fall injuring her left eye. A missed visit was documented for the week. The next skilled visit was completed on 4/10/09. There was no documented evidence the fall or the injury was	G 174		

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G 174	Continued From page 77	G 174		

reported to the physician. Subsequent visits did not reveal any assessments to the right eye injury. Employee #4 confirmed that she did not document the fall or document the assessed injuries. Employee #4 indicated she did not inform the physician regarding the fall and injury.

Patient #15

Patient #15 was admitted on 2/5/09 with diagnoses including paralysis, esophageal reflux, constipation, and non organic sleep disorder.

Patient #15 ' s Neuromuscular Disease Axial Visit Note dated 4/16/09 documented the resident sustained an open abrasion to the left forearm from a fall. The Employee #4 cleansed the area with wound cleanser, applied Neosporin, xerofoam and a dry sterile dressing.

There were no measurements taken of the wound and no signed physician orders for the treatment provided.

Patient #15 ' s Neuromuscular Disease Axial Visit Note dated 4/23/09 describes 2 healing wound areas on the forearm and the elbow from a fall sustained 2 weeks ago. There were no measurements taken of the wounds and no pictured location of the wound sites.

Patient #15 ' s Neuromuscular Disease Axial Visit Note dated 5/10/09 documented a new wound to the left upper arm. The nurse documented the wound was a " flap laceration " and Tegaderm was applied. There were no documented measurements taken and no signed physician order for the treatment.

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G 174	Continued From page 78 Patient #12 Patient #12 was admitted on 3/9/09 with diagnoses including hypertension and decubitis ulcer. Patient #12 was also taking Coumadin. Patient #12 had multiple wounds to the left lower extremity. Eight wounds were assessed, measured and documented on the Comprehensive Adult Assessment form dated 3/0/09. Weekly measurements were not taken on Patient #12 ' s wounds. The next set of measurements taken was 2 months later on 5/5/09. On 6/4/09 in the morning, Employee #14 confirmed the wound measurements should have been taken once a week. Patient #13 Patient #13 was admitted on 3/10/09 with diagnoses including diabetes, decubitus ulcer, hypertension, and chronic kidney disease. Patient #13 had multiple wounds to the buttocks area. The wounds were assessed, measured and documented on the Comprehensive Adult Assessment form dated 3/10/09. Weekly measurements were not taken on Patient #13 ' s wounds. The next sets of measurements taken were 2 months later on 5/6/09. On 6/3/09 in the afternoon, the Director of Nursing indicated wounds needed to be measured every week.	G 174		

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G 174	Continued From page 79 Patient #10 Patient #10 was admitted on 4/23/(03?) with diagnoses including pressure sores, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. Patient #10 had two pressure sores: one on the left hip and one on the coccyx. The clinical record for Patient #10 revealed the patient's wounds were not measured once a week (for the weeks of 2/1/09, 2/8/09, 3/22/09 and 4/5/09). When the wounds were measured, they were inconsistently identified and the measurements were incomplete. The clinical record for Patient #10 lacked a Weekly Wound Sheet Report describing the progress and development of wound status. The agency's policy and procedure for wound care indicated, "... 5. Measure the wound using centimeters (cm) indicating length, width, and depth.... ...12. Weekly Wound Sheet Report to describe the progress and development of wound status." According to the Outcome and Assessment Information Set (OASIS) transfer form, Patient #10 was transferred to an acute care facility on 5/18/09, secondary to wound infection/deteriorating wound status.	G 174		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and	G 176		

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progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.

This STANDARD is not met as evidenced by:
Based on interview and record review, the registered nurse failed to 1) inform the physician and other personnel of changes in conditions and needs for 3 of 15 patients (#11, 8, 14) and; 2) document the wounds adequately in the clinical record for 1 of 15 patients (#8).

Findings include:

Patient #11

Patient #11 was admitted to the agency on 1/23/09. The agency received a call on 4/13/09, from the caregiver, after hours, requesting a nurse come to assess Patient #11's ankle pain. The licensed practical nurse (Employee #6) made the visit. She instructed the patient to tell his physician at Patient #11's next visit, or to go to the emergency room if the pain increased. There was no evidence the LPN informed the case manager or the physician of her findings.

Patient #8

Patient #8 was admitted to the agency on 11/8/08 with three pressure sores to the lower back. The pressure sores measured 2 centimeters by 2 centimeters at that time. On 11/18/08, a wound care nurse assessed the wounds and documented evidence the wounds had not responded to the current therapy, and had increased in size, and recommended a change in wound care. The wound care nurse informed the

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G 176	Continued From page 81 primary nurse, Employee #5. There was no evidence the primary nurse informed the physician. The clinical record also revealed that the primary nurse failed to measure Patient #8's wounds as recommended by agency policy, and report the ongoing changes to the physician. Patient #4 Patient #4 was admitted on 10/23/08 with diagnoses including persistent insomnia, constipation, hypertension, and arthropathy. On 6/1/09 in the afternoon, a home visit was conducted at the home of Patient #4 with the registered nurse (RN) Employee #4. Patient #4 complained of right elbow pain. Employee #4 assessed slight swelling to the area and referred the pain and swelling to a fall sustained several months ago. On 6/2/09 in the afternoon, a telephone interview with Patient #4's son was conducted. The son indicated Patient #4 sustained a fall and injured her left eye at the end of March. The son indicated Patient #4 had a black eye for several weeks. The son had issues regarding nursing coverage. The son indicated that missed visits with the nurse had occurred 2 to 3 times in a six month period. The son indicated he was not contacted by the nurse prior to the missed visit. Missed skilled visits were made on the week of 1/27/09, 3/29/09, and 5/24/09. The 10/23/08, 12/17/08, 2/17/09, 4/20/09 plan of care ordered for skilled nursing once a week.	G 176		

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G 176	Continued From page 82 On 6/2/09 in the afternoon, Employee #4 indicated during the week of 3/29/09 a skilled visit was not made and Patient #4 sustained a fall injuring her left eye. A missed visit was documented for the week. The next skilled visit was completed on 4/10/09. There was no documented evidence the fall or the injury was reported to the physician. Subsequent visits did not reveal any assessments to the right eye injury. Employee #4 confirmed that she did not document the fall or document the assessed injuries. Employee #4 indicated she did not inform the physician regarding the fall and injury. Patient #14 Patient #14 was admitted on 7/13/08 (and reassessed after two subsequent admissions to the hospital) with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension. An undated "Care Summary" (OASIS) form indicated Patient #14 died unexpectedly in the home on 1/30/09. According to documentation on a Congestive Heart Failure (CHF) Axial Visit Note (CHFAVN) dated 7/22/08, the registered nurse (RN) failed to call and notify the physician of two plus pitting edema in Patient #14's bilateral lower extremities. On a CHFAVN dated 8/5/08, the RN documented Patient #14 was "... instructed to call MD (doctor) for any dizziness ... weigh daily and report gain of two to three pounds in 24 hours." On a CHFAVN dated 8/26/08, the RN	G 176		

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documented Patient #14 was "... instructed to continue daily weights and report weight gain of two pounds in 24 hours to MD."

On a CHFAVN dated 9/13/08, the RN documented Patient #14 was " ...complaining of shortness of breath ... very anxious ... two plus pitting edema in both lower extremities ... No edema to feet previously ..."

According to documentation on the CHFAVN dated 9/13/08, the RN advised the patient to go to the ER (emergency room), which the patient refused to do at that time. The RN advised the patient to sit up. The patient promised to go to Urgent Care if not feeling better in two hours.

An Outcome and Assessment Information Set (OASIS) Data Set revealed Patient #14 was admitted to the hospital (area for date of transfer left blank), reason for admission noted as "Other."

Out of 31 visits made, 12 notes had a weight documented. There was no indication of who weighed the patient or if the weight was "as stated" by Patient #14. On the 12/19/08 visit note, the RN documented Patient #14 had "stuffy lungs." The medical record lacked documented evidence indicating the RN had notified the physician the patient was non-compliant with daily weights or to report difficulty breathing. The last visit made by the RN was on 1/21/09.

On 6/4/09 at 10:20 AM, the RN indicated she instructed Patient #14 several times to weigh himself every day and record the weights but "the patient didn't." The RN admitted she "didn't think to measure the edema" in the patient's ankles. The RN did not weigh the patient herself during

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G 176	Continued From page 84 her visits.	G 176		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure the registered nurse instructed the patient/caregiver effectively to meet the needs of 2 of 15 patients requiring intravenous antibiotic therapy, wound care, and dietary teaching (#8, #10). Findings include: Patient #8 Patient #8 was admitted to the agency on 11/8/08, with the primary diagnosis of decubitus ulcers of the lower back. On admission it was identified that there were three stage two ulcers. The admission data indicated that Patient 8 was 69 years old, and lived by himself and was legally blind. He did have a paid caregiver. Patient #8 also had restricted movement with his right arm. Review of the clinical record revealed a deterioration of the wounds, requiring hospitalization. Upon Patient #8's return home, he had a peripherally inserted central catheter (PICC) placed, and subsequent intravenous antibiotic therapy every six hours (Zosyn) and every 12 hours (Vancomycin). The PICC line would need to be flushed with saline and Heparin after each dose of antibiotic.	G 177		

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G 177	Continued From page 85 There was no evidence the primary nurse, Employee #5 re-evaluated Patient #8's increased need of someone competent to administer the intravenous antibiotics. There was no evidence Employee #5 made sure the intravenous antibiotics were being administered as ordered. An interview with Employee #5 on 6/3/09, revealed the paid caregiver was a Medicaid homemaker came three times a day. This homemaker was not allowed to administer intravenous antibiotics. Employee #5 acknowledged that Patient #8 had a roommate, but Employee #5 could not identify when the roommate started to live with Patient #5. She also confirmed she never assessed the capabilities of this roommate to administer intravenous medications and maintain infection control procedures. Cross refer G 170 Cross refer G 172 Patient #10 Patient #10 was admitted on 4/23/03, with diagnoses including pressure sores, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. Throughout the clinical record, nursing notes revealed Patient #10 had "slow healing" wounds. The clinical notes of the licensed practical nurse (LPN) who did the majority of the visits, lacked documented evidence the LPN taught the patient/caregiver dietary measures to assist in wound healing.	G 177		

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G 177	Continued From page 86 The clinical record lacked documentation indicating the registered nurse (RN) case manager instructed the patient and the caregiver about nutritional/dietary measures to incorporate in aiding the wounds to heal. On 6/4/09 in the afternoon, the RN case manager indicated she had not done any teaching regarding a wound healing diet.	G 177		
G 178	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure the registered nurse supervised and taught the licensed practical nurse for 1 of 15 patients (#10). Findings include: Patient #10 Patient #10 was admitted on 4/23/03 with diagnoses including pressure sores, multiple sclerosis, neurogenic bladder and non-insulin dependent diabetes mellitus. During the certification periods of 1/21/09 - 3/21/09 and 3/22/09 - 5/20/09, the licensed practical nurse (LPN) was supervised by the registered nurse (RN) once each period during a telephone conversation with Patient #10's caregiver.	G 178		

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G 178	Continued From page 87 On 6/4/09 at 1:40 PM, the RN explained, "I asked (Patient #10's) caregiver if the LPN was doing what she was supposed to ... caring for the wounds ... and she said 'yes'."	G 178		
G 196	484.34 MEDICAL SOCIAL SERVICES The social worker participates in the development of the plan of care. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure that the medical social services actively participated in the development of the plan of care for 1 of 15 patients (#11). Findings include: Patient #11 Patient #11 was admitted to the agency on 1/23/09, with the primary diagnoses of atrial fibrillation, hypertension and spinal stenosis. He required rehospitalization twice from 3/10-3/15/09 and 3/23-4/16/09. The clinical record revealed the patient had a medical social services visit on 4/22/09. The clinical note written by the medical social worker indicated Patient #11 required assisted living facility placement. Patient 11's durable power of attorney for health care (DPOAHC) was to arrange this. The clinical record did not identify the name of this individual. There were no legal documents in the clinical record to indicate Patient #11 had a DPOAHC. There was no evidence that the medical social worker contacted the primary nurse case	G 196		

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G 196	Continued From page 88 manager. A telephone interview with the medical social worker on 6/5/09, confirmed she did not notify the case manager about her visit, or the direction that the DPOAHC was to arrange alternate placement. When asked if she contacted anyone, the medical social worker said that she called the office, but could not recall who she spoke to, acknowledging she may have only spoken to a clerical staff member.	G 196		
G 202	484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: The agency: failed to complete a performance review of each home health aide no less frequently than every 12 months (214); failed to have the home health aide receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient (215); failed to provide adequate written patient care instructions for the home health aide to care for the patient. Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section (224); failed to supervise the home health aide with the appropriate personnel. If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided	G 202		

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G 202	Continued From page 89 by the appropriate therapist (228); failed to ensure supervisory visits of the home health aides were conducted every 14 days. The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks (229). The cumulative effect of these systemic problems resulted in the agency's inability to ensure the provision of federally mandated skilled nursing services.	G 202		
G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must complete a performance review of each home health aide no less frequently than every 12 months. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure a performance evaluation was completed every 12 months for 1 of 1 certified nursing assistant. Findings include: Employee #8 was hired on 5/10/07 as a certified nursing assistant (CNA). Employee #8's personnel file lacked documented evidence of a performance evaluation for the past two years. On 6/12/09 in the afternoon, the Administrator explained, "We had a policy but we didn't implement it."	G 214		
G 215	484.36(b)(2)(iii) COMPETENCY EVALUATION &	G 215		

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G 215	Continued From page 90 IN-SERVICE TRAI The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure at least 12 hours of in-service training per year was provided for 1 of 1 home health aide during the past two years (#8). Findings include: Employee #8 was hired as a certified nursing assistant on 5/10/07. Employee #8's personnel file lacked documented evidence of 12 hours of in-service training per year during the past two years. On 6/12/09 in the afternoon, the Administrator acknowledged Employee #8 did not meet the in-service training requirements.	G 215		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse prepared specific written care instructions for the home health aide	G 224		

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G 224	Continued From page 91 to follow for 1 of 15 patients (#5). Findings include: Patient #5 Patient #5 was admitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness. In the column under "Bath" on the HHA (home health aide) Care Plan, the options "Tub/Shower", "Bed-Partial/Complete", Assist Bath-Chair" were all selected marked "Total Support." There was no clear indication on the HHA Care Plan exactly what method the HHA was to utilize while providing Patient #5 with personal care.	G 224		
G 228	484.36(d)(1) SUPERVISION If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the home health aide were being appropriately supervised by the registered nurses for 2 of 15 patients (#8, #9). Findings Include:	G 228		

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G 228	Continued From page 92 Patient #8 Patient #8 was a patient of the agency from 11/8/08 through 4/21/09. He had home health aide services twice a week for his entire home health stay. Patient #9 Patient #9 was admitted to the agency on 10/17/07. Review of her last two recertification periods revealed she had home health aide services twice a week from 2/8/09, through the current date 6/3/09. Review of both clinical records revealed no documentation of aide supervision by the registered nurse. An interview with Employee #5, a registered nurse was conducted on 6/3/09. She acknowledged that she did not perform any supervisory visits to evaluate the certified nursing assistants compliance with the home health aide plan of care. Employee #5 reported she was not aware this was her responsibility. Employee #5 had been an employee of this agency for more than a year. Cross refer to G 229	G 228		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.	G 229		

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G 229	Continued From page 93 This STANDARD is not met as evidenced by: Based on record review, interview, and document review, the agency failed to ensure the registered nurse made on-site visits to evaluate the home health aide's compliance with the plan of care for 3 of 15 patients (#8, #9, #5). Findings include: Patient #8 Patient #8 was a patient of the agency from 11/8/08 through 4/21/09. He had home health aide services twice a week for his entire home health stay. Patient #9 Patient #9 was admitted to the agency on 10/17/07. Review of her last tow recertification periods revealed she had home health aide services twice a week from 2/8/09, through the current date 6/3/09. Review of both records revealed no documentation of aide supervision by the registered nurse. Both patients were assigned Employee #5 as the primary nurse. An interview with Employee #5, a registered nurse was conducted on 6/3/09. She acknowledged that she did not perform any supervisory visits to evaluate the certified nursing assistants compliance with the home health aide plan of care. Employee #5 reported she was not aware this was her responsibility. Employee #5 had been an employee of this agency for more than a year.	G 229		

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G 229	Continued From page 94 Cross refer to G 228 Patient #5 Patient #5 was admitted on/26/06 and readmitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness. The certified nursing assistant (CNA) was scheduled to see Patient #5 two times a week for nine weeks, beginning 1/11/09 through 3/11/09. The CNA saw Patient #5 two times a week for eight weeks, prior to the patient being hospitalized on 3/5/09. During these eight weeks, no documented evidence of a supervisory visit was noted on any CNA visit notes or registered nurses' (RN) notes. During the certification period of 3/12/09 - 5/10/09, the CNA saw Patient #5 two times a week for nine weeks. The registered RN performed supervisory visits on 3/24/09 and 4/23/09. According to the agency's policy for Home Health Aide supervision, "...Home health aide services shall be supervised at least every 2 weeks with an on-site visit to the patient home for the patient receiving skilled services..."	G 229		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In	G 236		

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addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

This STANDARD is not met as evidenced by:
Based on interview, record review, and document review, the agency failed to
maintain accurate and complete medical records, including but not limited to, histories and physicals for 5 of 11 active patients (#5, #6, #11, #7, #9) and 2 of 4 closed patient records (#2, #8).

Findings include:

Review of five active clinical records and two closed records revealed the individual patients had signed releases for the agency to obtain medical records from their physicians. The agency failed to send the releases to the physicians, requesting the medical records, including histories and physicals.

The four active records were:

Patient #5, admitted on 7/26/06, and re-admitted on 3/11/09.
Patient #6, admitted on 5/16/09.
Patient #11, admitted on 1/23/09.
Patient #9, admitted on 10/17/07.
Patient #7, on 1/5/09.

The two closed records were:

Patient #2, on service from 8/29/08 to 12/3/09.

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G 236	Continued From page 96 Patient #8, on service from 11/8/08 to 4/21/09. The policy titled "Clinical Records/Medical Record Retention," from Briggs Corporation, Home Health Agency JCAHA Manual read, "...2. In addition to the Plan of Care, the clinical record shall contain appropriate identifying information, including, but not limited to: ...s. Copy of history and physical ..." An interview with the Director of Nursing and the Administrator on 6/2/09 at 2:00 PM confirmed that no request for a history and physical for these patients had been sent to the primary physicians.	G 236		
G 242	484.52 EVALUATION OF THE AGENCY'S PROGRAM This CONDITION is not met as evidenced by: The agency: failed to ensure written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (G243); failed to ensure the evaluation consists of an overall policy and administrative review and clinical record review (G244); failed to ensure the evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient (G245); failed to ensure the results of the evaluation are reported to and acted upon by those responsible for the operation of the agency (G246); failed to ensure the policies and administrative practices of the agency were reviwed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient (G248); and failed to ensure there is a continuing review of clinical records for each 60 day period that a	G 242		

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G 242	Continued From page 97 patietn receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care (G251). The cumulative effect of these systemic problems resulted in the failure of the agency to evaluate their program according to statutory mandate.	G 242		
G 243	484.52 EVALUATION OF THE AGENCY'S PROGRAM The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. This STANDARD is not met as evidenced by: Based on interview, the facility failed to have written policies on the evaluation of the agency's program. Findings include: On 6/9/09 in the morning, the Quality Management Director, Employee #2, indicated there was no written policy regarding the agency's quality assurance program.	G 243		
G 244	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. This STANDARD is not met as evidenced by: Based on interview, the agency failed to complete	G 244		

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an evaluation of the overall policy, administrative, and record review.

Findings include:

On 6/9/09 in the morning, the Quality Management Director, Employee #2, indicated there was no written policy regarding the agency's quality assurance program.

On 6/4/09 in the afternoon, Employee #2 could not produce quarterly evaluation results for the 2008 second, third, and fourth quarters. Employee #2 could not produce the 2009 first quarter review results. Employee #2 indicated that the reviews from the above dates were not complete so she could not identify any issues from the reviews.

On 6/4/09 in the afternoon, the Director of Nursing (DON) indicated on site home evaluations, to determine if care was performed properly by the field staff, were not being done.

On 6/4/09 in the afternoon, the Administrator indicated the agency stopped sending questionnaires 2 years ago to patients homes to evaluate the care the field staff were providing.

Employee #2 indicated the agency had no process to determine if goals had been met. When issues that were identified and in-services were implemented to correct the issues there was no follow up evaluation to assess if the in-services were effective.

Patient #4

Patient #4 was admitted on 10/23/08 with

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G 244	Continued From page 99 diagnoses including persistent insomnia, constipation, hypertension, and arthropathy. On 6/1/09 in the afternoon, a home visit was conducted at the home of Patient #4 with the registered nurse (RN) Employee #4. Patient #4 complained of right elbow pain. Employee #4 assessed slight swelling to the area and referred the pain and swelling to a fall sustained several months ago. On 6/2/09 in the afternoon, a telephone interview with Patient #4's son was conducted. The son indicated Patient #4 sustained a fall and injured her left eye at the end of March. The son indicated Patient #4 had a black eye for several weeks. The son had issues regarding nursing coverage. The son indicated Employee #4 would contact her mother (Patient #4) and inform her that she would not be visiting her that week. The son would receive a call from his mother informing him the nurse would not be coming to do a visit. The son indicated that missed visits with the nurse had occurred 2 to 3 times in a six month period. The son indicated he was not contacted by the nurse prior to the missed visit. Missed skilled visits were made on the week of 1/27/09, 3/29/09, and 5/24/09. The 10/23/08, 12/17/08, 2/17/09, 4/20/09 plan of care ordered for skilled nursing once a week. On 6/2/09 in the afternoon, Employee #4 indicated during the week of 3/29/09 a skilled visit was not made and Patient #4 sustained a fall injuring her left eye. A missed visit was documented for the week. The next skilled visit was completed on 4/10/09. There was no documented evidence the fall or the injury was	G 244		

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G 244	Continued From page 100 reported to the physician. Subsequent visits did not reveal any assessments to the right eye injury. Employee #4 confirmed that she did not document the fall or document the assessed injuries. Employee #4 indicated she did not inform the physician regarding the fall and injury. Employee #4's schedule was reviewed for the week of 3/29/09. Employee #4 documented 18 missed visits on 18 patients for the week. On 6/3/09 in the morning, the DON indicated she was not aware Employee #4 had that many missed visits for the week. The DON indicated they had no system to alert her that a nurse missed that many visits for one week. On 6/4/09 in the morning, the Administrator was not aware that Employee #4 missed 18 visits in a one week period.	G 244		
G 245	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement a process to evaluate the agency's program. Findings include: On 6/4/09 in the afternoon, the Administrator indicated the agency stopped sending questionnaires over two years ago to patients	G 245		

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G 245	Continued From page 101 homes to evaluate the care the field staff were providing. Employee #2 indicated the agency had no process to determine if goals had been met. When issues that were identified and in-services were implemented to correct the issues there was no follow up evaluation to assess if the in-services were effective. Patient records that were reviewed were not re-evaluated after corrections were made.	G 245		
G 246	484.52 EVALUATION OF THE AGENCY'S PROGRAM Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency. This STANDARD is not met as evidenced by: Based on interview and document review, the agency failed to act upon results of their evaluation. Findings include: On 6/9/09 in the morning, the Quality Management Director, Employee #2, indicated there was no written policy regarding the agency's quality assurance program. On 6/4/09 in the afternoon, Employee #2 could not produce quarterly evaluation results for the 2008 second, third, and fourth quarters. Employee #2 could not produce the 2009 first quarter review results. Employee #2 indicated that the reviews from the above dates were not complete so she could not identify any issues from the reviews. There was no documented	G 246		

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G 246	Continued From page 102 evidence the reviews were reported to the governing body to review and the governing body had not asked for the missing reports. On 6/4/09 in the afternoon, the Director of Nursing (DON) indicated on-site home evaluations, to determine if care was performed properly by the field staff, were not being done. On 6/4/09 in the afternoon, the Administrator indicated the agency stopped sending questionnaires over 2 years ago to patients homes to evaluate the care the field staff were providing. Employee #2 indicated the agency had no process to determine if goals had been met. When issues that were identified and in-services were implemented to correct the issues there was no follow up evaluation to assess if the in-services were effective.	G 246		
G 248	484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by: Based on document review provided by the agency and the contents of this report, the agency failed to provide evidence they promoted patient care that was appropriate, adequate, effective and efficient.	G 248		

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G 248	Continued From page 103 Findings include: Review of clinical records identified in this report failed to provide documented evidence of the following: - Communication between staff and the physician was being performed - Physician orders were being followed or orders obtained when new treatments or medications were implemented -Proper wound assessments were implemented -Proper infection control techniques were performed -The patient medications were not accurately identified or updated In light of the contents of this report, the program evaluation failed to indicate how the agency determined compliance with this regulation.	G 248		
G 251	484.52(b) CLINICAL RECORD REVIEW There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure record review occurred routinely every 60 days in order to determine if the plan of care was appropriate and needs were adequately being met for 9 of 15 patients (#1, #5, #7, #10, #14, #2, #8, #9, #11). Findings include: Nine of 15 medical records lacked documented	G 251		

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G 251	Continued From page 104 evidence indicating patients were re-evaluated to determine the appropriateness of care, adequacy in meeting their needs and to assess the need for continuation of services. Several of the 9 patients had been on service for over a year. On 6/4/09 in the morning, the Administrator agreed they had not reviewed the records the way they should have.	G 251		
G 303	484.48 CLINICAL RECORDS The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. This STANDARD is not met as evidenced by: Based on document review and record review, the agency failed to ensure that discharge summaries were completed for patients that were discharged for two of four closed records (#2, #8). Findings include: Review of the agency policy identified as C-760, Discharge Summary defined the procedure for patients discharged from the agency. The policy specified that a discharge summary would be completed for clients discharged from the agency. The purpose of was to record a summary of the care received by the client from the start of care through discharge. It would also be available to the physician upon request. This summary would incorporate at a minimum,	G 303		

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G 303	Continued From page 105 the following: Admission and discharge dates, services provided, diagnoses, status upon admission and discharge, notification of discharge, and reason for discharge. The discharge summary would also include transfer information, if applicable; unmet needs and referrals if made as well as instructions provided to the family. Review of two closed records, Patient #2 and Patient 8, revealed that both of these patients expired. Patient #2 had expired 12/3/08 and Patient #8 expired 4/21/09. The clinical records revealed no discharge summaries. Cross refer G 251	G 303		
G 320	484.20 REPORTING OASIS INFORMATION HHAs must electronically report all OASIS data collected in accordance with §484.55 This CONDITION is not met as evidenced by: The agency failed to encode OASIS data that must accurately reflect the patient's status at the time of assessment (G322). The cumulative effect of this systemic practice resulted in the failure of the agency to deliver services statutorily mandated by the Federal regulations for acceptance of patients, the plan of care and medical supervision.	G 320		
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on interview, it was determined the agency	G 322		

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G 322	Continued From page 106 failed to ensure that collected OASIS data accurately reflected the patient's status at the time of assessment for all patients. Findings include: Interviews independently with the Administrator, the Director of Patient Services and the Quality Assurance staff during the survey regarding discrepancies in the OASIS data collected revealed a necessity to have a collective meeting with these individuals. A group interview with the Administrator, the Director of Patient Services (DoPS) and the Quality Assurance (QA) staff on 6/3/09, revealed the following process for collecting and encoding OASIS data. According to the Administrator, the Director of Patient Services and the Quality Assurance staff, they were concerned about entering the OASIS data timely. The agency's process was that all OASIS data was sent to a data processing staff member who lived out of state. This would be done before any OASIS data was reviewed or proofed by the DoPS or QA for accuracy. The data processing staff member would enter the data, formulating a plan of care and then send the information back to the agency. The OASIS data would then be entered into the system and the patient's plan of care would be proofed and corrected at this time. The Administrator, the Director of Patient Services and the Quality Assurance staff confirmed this had been standard practice for all OASIS submissions.	G 322		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a	G 337		

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review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

This STANDARD is not met as evidenced by:
Based on record review and document review (medication profiles and home medication lists), the agency failed to ensure that medications were evaluated consistently to provide the patient accurate medication regimes in 5 of 15 patients. (#8, #11, #1, #5, #7, #14).

Findings include:

Patient #8

Patient #8 was a 70 year old male who was admitted to the agency on 11/5/08 with the primary diagnoses of pressure sores to the buttocks. During his home health stay he required hospitalization on 1/30/09-2/2/09. Upon his return to his home, and resumed agency care, he had a peripherally inserted central catheter (PICC) line for intravenous antibiotics. The orders were that the PICC line was to be flushed with five cubic centimeters (cc) of 100 unit/cc Heparin flush every day using SASH (saline, antibiotic, saline heparin) protocol. The saline and heparin flushes were not added to the medication profile.

Patient #11

Patient #11 was a 93 year old male who had been on service since 1/23/09. A medication profile list completed 4/16/09, revealed Patient #11 was taking Warfarin (Coumadin) 2 milligrams (mg),

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one tablet at bedtime. Patient #11 was recertified for the period of 5/23-7/21/09. This recertification revealed that Patient #11 was prescribed Warfarin 2 mg, two tablets (4 mg) daily. This profile indicated that the Warfarin dose had been changed on 5/17/09, but the previous medication profile had not been updated.

A nurses note dated 5/29/09, revealed that the Coumadin had been decreased to 2 mg, once a day, but the medication profile, as of 6/4/09 had not been revised.

Patient #1

Patient #1 was admitted on 12/31/08, with diagnoses including chronic airway obstruction, shortness of breath, long-term use of blood thinners, and coronary artery disease.

The Medication Profile revealed Patient #1 had been taking Lasix 20 mg one tablet every day and Coreg 12.5 mg one tablet every morning. On a SN Visit Note dated 1/16/09, the LPN documented "Lasix 10 mg (mg) change...Coreg D/c'd" (discontinued).

Patient #1's clinical record lacked documented evidence the nurse obtained a physician's order to change the medications. The Medication Profile was not updated to reflect the changes made. There was no documentation indicating the LPN spoke with the registered nurse who was managing the case with regard to the medication changes.

A visit note written by a licensed practical nurse (LPN) and dated 2/3/09, indicated Patient #1's

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G 337	Continued From page 109 medications were changed as follows: -- Coumadin dose was changed to 5 mg 1 tablet on Monday, Tuesday, Wednesday, Thursday and Saturday; 1.5 tablets on Friday; and -- Coreg 3.125 mg one tablet by mouth twice a day was restarted. According to the initial Medication Profile in the medical record, Patient #1 was taking Coumadin 5 mg 1 tablet by mouth on Sunday, Wednesday and Saturday and 1.5 tablet on Monday, Tuesday, Thursday and Friday. The Medication Profile was not updated with the changes. The clinical record lacked a physician's order for Patient #1's medication changes as noted on the 2/3/09 SN visit note. A visit note written by a LPN and dated 2/27/09, indicated Patient #1 was taking Azithromycin, Mucous Relief and Tessalon Perles. The medical record lacked documented evidence of a physician's order for the new medications. The Medication Profile was not updated with the new medications. The 2/27/09 visit note indicated Patient #1's Coumadin was changed to 7.5 mg on Monday, Wednesday and Friday; and 5 mg on Tuesday, Thursday and Saturday. There was no physician's order for these changes. The Medication Profile was not updated with the changes. A visit note written by a LPN and dated 5/9/09, indicated that as of 5/6/09, Patient #1 was to take Coumadin "7.5 mg on Wednesday, Thursday and	G 337		

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Friday; 5 mg on Saturday and Sunday this week. Next week 7.5 mg Monday, 5 mg Tuesday, 7.5 mg Wednesday, 5 mg Thursday, 7.5 mg Friday and 5 mg on Saturday/Sunday."

Patient #5

Patient #5 was admitted on 7/26/06 and readmitted on 3/11/09 with diagnoses including diabetes mellitus, chronic skin ulcer and generalized muscle weakness.

During a home visit on 6/2/09 in the morning, Patient #5's caregiver presented the following medications for review:

-- Glipizide 10 milligrams 1/2 tablet by mouth at breakfast
-- Zantac 150 milligrams one tablet by mouth twice a day
-- Stool softener one by mouth twice a day

The Plan of Care for the certification period of 5/10/09 - 7/08/09, revealed Patient #5 was to be taking:

-- Glipizide 25 milligrams one tablet by mouth every morning
-- Zantac 75 milligrams one tablet by mouth every day

The Plan of Care (5/10/09 - 7/08/09) did not include stool softener. Patient #5's caregiver indicated the patient had been taking the stool softener for two months.

Patient #7

Patient #7 was admitted on 1/5/09 with diagnoses

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G 337	Continued From page 111 including non-insulin diabetes mellitus, congestive heart failure and hyperlipidemia. The initial Medication Profile (MP) indicated Patient #7 was taking: -- Humalog Insulin 18 units subcutaneously (SQ) before breakfast and lunch and 12 units before dinner; -- Lantus Insulin 36 units SQ at bedtime; -- Lipitor 80 milligrams by mouth at bedtime; and -- Diovan 80 milligrams by mouth every morning. A Verbal Order Confirmation dated 1/24/09, revealed the registered nurse (RN) spoke with Patient #7's physician and received/wrote verbal orders for 1) Lasix 20 milligrams by mouth every day; and 2) Potassium Chloride 10 milli-equivalents by mouth every day. The initial MP was not updated to reflect Patient #7 was taking Lasix or Potassium Chloride. The MP for the certification period of 3/6/09 - 5/4/09 listed Simvastatin 80 milligrams by mouth at bedtime. The clinical record lacked a physician's order to discontinue Lipitor and start Simvastatin. On 6/2/09 in the morning, during a home visit and prior to the nurse's arrival, Patient #7 presented (as being taken at that time), the following medications and dosages (per bottle label and physician's instructions to the patient): -- Diovan 80 milligrams by mouth every day -- Humalog (insulin) 12 units before breakfast, 14 units at lunch and 14 units at dinner time -- Novolog 14 units before every meal three	G 337		

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G 337	Continued From page 112 times a day -- Lantus 36 units SQ at bedtime -- Simvastatin 40 milligrams by mouth every night -- Lasix 20 milligrams one tablet every morning -- KCL (potassium chloride) 10 milli-equivalents by mouth every day Patient #7 indicated he had been taking Simvastatin 40 milligrams for "about 6 months now (and) Diovan 80 milligrams for quite awhile ... before Prestige Home Health started coming out." Patient #14 Patient #14 was admitted on 7/13/08 with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension. According to the plan of care, Patient #14 was taking several medications, including Actos 45 milligrams one tablet by mouth every morning. On a "Congestive Heart Failure Axial Visit Note" (CHFAVN) dated 7/22/08, the registered nurse (RN) documented Patient #14, "...saw nephrologist yesterday, MD placed Actos on hold as pt (patient) states edema and SOB (shortness of breath) are from Actos ..." The Medication Profile (MP) for Patient #14 was not updated to reflect this change in the Actos order. A CHFAVN dated 7/22/08 revealed Patient #14 demonstrated evidence of administering oxygen safely. The MP did not have oxygen listed as a treatment the patient was receiving.	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297089	A. BUILDING _____ B. WING _____	06/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 337	Continued From page 113 A Verbal Order Confirmation (VOC) dated 7/22/08, revealed Patient #14 was taking Colchicine 0.6 milligrams by mouth twice a day for two weeks. The VOC dated 7/22/08, indicated Patient #14 was to increase Lasix dosage to 80 milligrams by mouth every day. On a CHFAVN dated 7/25/08, the RN documented "... Pt on FeSo4 (Iron supplement) ..." On a CHFAVN dated 8/8/08, the RN documented, "... Pt states he took med (medication) to lower K+ (Potassium). On a CHFAVN dated 8/12/08, the RN documented, "... Pt given K-exilate (Kayexalate) to lower K+ (Potassium). On a CHFAVN dated 8/19/08, the RN documented, "... started on Procrit BID (twice a day) inj (injections) given by MD..." On a CHFAVN dated 9/6/08, the RN documented, "... Vit. (Vitamin) D tab 50,000 U (units) q (every) week..." The MP was not updated to show the addition of Colchicine, the increase of Lasix, the addition of an Iron supplement, the addition of Kayexalate, the addition of Procrit, the addition of Vitamin D. On the MP prepared at the time of recertification for the period of 9/11/08 - 11/09/08, "B Complex" (Vitamin B supplement) was listed as having been started on 9/4/08 (same day as Vitamin D).	G 337		

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G 337	Continued From page 114 The CHFAVN dated 9/6/08 did not contain documentation Patient #14 was educated regarding the Vitamin B supplement (same day patient was instructed on Vitamin D). Subsequent CHFAVN's lacked documented evidence the patient was educated regarding Vitamin B. On a CHF Visit Note dated 10/15/08, the RN documented Patient #14 "... was instructed that Sertraline is an antidepressant ..." The MP for the certification period of 9/11/08 - 11/09/08 was not updated to reflect the newly added Sertraline. The MP for the certification period of 9/11/08 - 11/09/08 did not include oxygen.	G 337		
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the recertification assessment visit was made during the last five days of the initial 60 day certification period for 1 of 15 patients (#14).	G 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 339	Continued From page 115 Findings include: Patient #14 Patient #14 was admitted on 7/13/08 with diagnoses including gastrointestinal bleed, anemia, non-insulin diabetes mellitus, congestive heart failure and hypertension. The initial plan of care for the certification period of 7/13/08 through 9/10/08 indicated the skilled nurse (SN) was to see Patient #14 two times a week for three weeks and then one time a week for six weeks. The registered nurse (RN) case manager saw Patient #14 one time the first week; two times a week for three weeks; and then one time a week for four weeks. The RN performed the recertification assessment visit the day after the certification period had ended. The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days.	G 339		